



SYNERGIA

**Evaluation of the New  
Graduate Nurse  
employment scheme  
through the Very Low  
Cost Access initiative: A  
mid-point evaluation  
report**

Report for the Ministry of  
Health

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4 November 2014

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## ACKNOWLEDGEMENTS

We would like to acknowledge the support from the sector in supporting the data collection undertaken for this evaluation. We would particularly like to thank all the Very Low Cost Access practices involved in the initiative and the District Health Boards and PHO staff for giving their time and insights into the implementation and achievements of the initiative to date.

We would also like to acknowledge the support and insights from key stakeholders at the Ministry of Health.

## 1. EXECUTIVE SUMMARY

The one-off funding for new graduate nurses (NGN) is part of the Very Low Cost Access (VLCA) Practice Sustainability initiative that provided additional funding for qualifying general practices serving 50% or more high needs populations (defined as Māori, Pacific, or Quintile 5 populations). The initiative was introduced by the Ministry of Health in 2013/2014 partly in response to evidence suggesting that some VLCA practices with high proportions of high needs enrolees were experiencing sustainability issues due to a mix of financial, workforce, clinical and social complexity issues (Brown and Underwood, 2013).

This mid-point evaluation report focuses on the one-off funding for the new graduate nurse (NGN) for the VLCA practices. Specifically, this report draws on the findings from a practice profiling analysis of the 48 VLCA practices' application forms and an online survey with 171 practice, DHB and PHO staff currently involved in the implementation of the initiative. This analysis is brought together to provide an interim evaluation of the implementation and impacts of the initiative to date.

It is useful to note that this evaluation reflects approximately eight months of implementation, with a follow-up phase of evaluation designed to provide a deeper insight into the implementation and impacts of the initiative. The next phase will also provide the opportunity to further explore the views and experiences of the stakeholders through conducting interviews and an analysis of existing practice data.

### 1.1 PRACTICE PROFILING

A quarter of the VLCA practices with a NGN were located in Counties Manukau DHB (25% or 12 practices), and almost half of the practices were located in an upper North Island DHB (46% across Northland, Auckland, Waitemata, and Counties Manukau DHB).

Most of the VLCA practices had between 2 and 9 GPs, with 38% of practices having 2-4 GPs (18) and 33% having 5-9 GPs.

Two-fifths of the VLCA practices had an enrolled population of between 2,000 to 5,000 patients (40% or 19 practices), and a third of practices had between 5,000 and 10,000 enrolled patients (33% or 16).

As per the VLCA requirements, practices receiving additional funding or one-off funding for a new graduate nurse had 50% or higher enrolled populations classified as high needs. Two-fifths of the



VLCA practices had a very high proportion of High Needs enrolled population, with over 80% of their patients in this group (42% of practices had 80%+ High Needs patients).

In terms of providing for Māori patients, there was a fairly even spread of practices in the initiative - around a third of practices had less than 30% Māori patients, a third had between 30-60% Māori patients, and a third had more than 60% of their enrolled population identifying as Māori.

Almost half of the VLCA practices had less than 10% of their population identifying as Pacific (46% or 22 practices), although seven had over 70%.

Of the 48 VLCA practices, ten had previously employed a NGN before the VLCA initiative took place (21%).

The VLCA initiative provided funding for 48 New Graduate Nurses.

Almost half of the NGNs involved in the initiative identified as NZ European (46% or 22 NGNs). A quarter identified as Māori (25% or 12) and 17% identified as Pacific (8 NGNs).

## **1.2 INTENDED IMPLEMENTATION**

The application forms provided a useful insight into the intended implementation of the VLCA Sustainability Initiative.

In terms of the one-off funding for the NGN, the applications have identified the role of the NGN in supporting an increased focus on nursing care at the practice. The applications also identified the range of approaches that the practices intended to use to support the NGN. This often included support from the DHB through the NETP programme, as well support from existing practice staff and providing specific training.

Sustaining the employment of the NGN role was often associated with intentions to increase enrolments, although opportunities for growing the practice through the wider VLCA initiative and supports from the DHB and PHO were also often cited. Some of the practices also acknowledged that the continued employment of the NGN was uncertain at the time of the application. The practices did offer some interesting ideas for sustaining the role. This included partnering with other practices and or the PHO to sustain the role.

### 1.3 UNDERSTANDING CURRENT IMPLEMENTATION AND IMPACTS

The survey has provided a valuable insight into the current implementation and impacts of the NGN role at the VLCA practices. The 171 responses to the survey included the views and experiences of the NGNs, nurse preceptors, business owners and other practice staff, as well as the District Health Board (DHB) and Primary Health Organisations (PHOs) involved in the initiative.

In terms of implementation the findings suggest that:

- The time available and the timing of the application process could be improved to support the practices in applying for the fund and being able to identify an NGN closer to the time of their graduation.
- The practices were well prepared for the arrival of the NGN and had a good induction process to support them.
- Only a few practices found it harder to understand their role in supporting the NGN and the level of support that an NGN required. This was most common for those who had not had an NGN before.
- The NGNs were well integrated into their practices and were a valued member of the practice team.

In terms of professional development and support, the survey indicates that:

- The NGNs had a clear professional development plan that was supported through external training opportunities and the internal support and mentoring from the practice staff and NETP coordinator.
- The nurse preceptor role was particularly valued by the NGN.
- The NETP programme provided the NGNs with the opportunity to socialise with other graduates and develop their skills and knowledge. Many of the NGNs however, suggested that the relevance of this training could be improved by providing a greater focus on the primary care and community setting.

In terms of impact, the NGN nurse role had:

- Increased the support available to other clinicians.
- Increased practice performance on targets.
- Increased the availability of capable staff to support succession planning.
- Introduced new skills or processes to other staff.

In terms of patient experience, the respondents suggested that the NGN role had:

- Improved patients' experience.
- Increased the time available to support patients' social needs.
- Increased the number of staff available for appointments at the practices.
- Increased the number of patients seen at the practice.
- Increased the number of appointments available to patients.

With regards to the business model and financial impacts, the NGN role had influenced the business model at some of the practices and increased the fiscal sustainability of nearly half. However, there was generally less support for these types of influences than the impacts on the practice and the patient experience.

Half of the practice staff suggested that the NGN role had increased connections between the practice and the PHO, and the practice and the DHB.

The survey identified a range of benefits of the NGN role at the practices including:

- Bringing more Māori and Pacific NGNs into primary care and developing the sustainability of the workforce for VLCA practices.
- Reducing the burden on the existing practice team.
- Developing mentoring and leadership skills within the practice through the support provided to the NGN.
- Having a culturally appropriate and responsive NGN.
- Seeing the benefits for patients.
- Having more resources to support succession planning.
- Increasing performance on targets.

For the NGNs, key benefits included the level of support they were provided with while gaining experience in the workplace. Being employed was also valued.

When identifying the future intentions of the NGN role at the VLCA practices:

- All of the NGNs intended to remain in primary care after the initiative ends, and all but one wanted to remain at their current VLCA practice.
- The practices would also like to sustain the employment of the NGN, although funding was identified as the key challenge to achieving this.
- The practices were also willing to have NGNs in the future, even if this was not part of the VLCA Sustainability Initiative.

For some practices, key challenges to implementation included the time that needed to be spent on training the NGN, training for the NGN that focused on secondary care services and managing practice staff expectations of the NGN role and scope.

Ideas for improvements suggested by the stakeholders included:

- Extending the timeframe of the initiative to go beyond twelve months, suggestions ranged between two and five years.
- An extended timeframe was considered to be important to realising the full benefits and potential of the initiative by some practice managers and business owners.
- Having greater focus on the primary care and community setting in the NETP programme.
- Partial ongoing funding from the government for the NGN position to support sustainability, especially for smaller practices.
- Improving the application process through increasing the time available to put together an application and aligning the timing more closely to the nurses graduations.
- Increasing NGN placements across primary care in general, not just VLCA practices.
- Outline the level of support required for an NGN, particularly for those practices who have not had an NGN before.
- Clearer contracts and reporting requirements from the outset of the initiative.

## 1.4 CONCLUSIONS

This report has provided a useful insight into the views and experiences of key stakeholders involved in the implementation of the NGN employment scheme through the VLCA initiative.

Overall, the findings provided support for the successful implementation and initial impacts of the one-off funding for the new graduate nurse component of the VLCA Sustainability Initiative. It will be important to further validate and explore these impacts in the next phase of the evaluation.

## 2. INTRODUCTION

The one-off funding is part of the Very Low Cost Access (VLCA) Practice Sustainability initiative that provided additional funding for qualifying general practices serving high needs populations (defined as Māori, Pacific, or Quintile 5 populations). The initiative was introduced by the Ministry of Health in 2013/2014 partly in response to evidence suggesting that some VLCA practices with high proportions of high needs enrolees were experiencing sustainability issues due to a mix of financial, workforce, clinical and social complexity issues (Brown and Underwood, 2013).

The VLCA Practice Sustainability Initiative involves two components. The first provides ongoing funding of \$4 million per annum for VLCA practices with 50% or more high needs enrolees. The second component involves one-off supplemental funding of \$2.4 million to employ and pay salaries for 48 NGNs for 12 months in qualifying practices. This one-off funding was intended to support VLCA practices to:

- Address some of their ongoing workforce issues e.g. ageing workforce and poor alignment between patients and nursing workforce demographics.
- Support graduate nurses to transition to primary healthcare practices in a planned programme associated with the Nurse Entry to Practice programme.

In the longer term the initiative was designed support VLCA practices to:

- Implement additional service provision.
- Expand patient care.
- Enhance workforce sustainability.

The one-off funding to employ new graduate nurses (NGNs) is being evaluated by Synergia. At this stage, there has been an across site analysis of the practices involved in this component of the initiative. This involved:

- Practice profiling to identify the demographic, geographic, rural, provincial and urban spread of the VLCA practices and the ethnicity of the NGNs,
- An analysis of documentation on the intended implementation and sustainability of the one-off funding for practice sites and
- An online survey with key stakeholders from all VLCA general practices involved in the scheme.

This across site analysis provides an overarching insight into the implementation and impacts of the one-off funding. This report draws on this across site analysis to evaluate the implementation and impacts of the initiative across participating VLCA practices. It is important to note that this report reflects the interim evaluation findings of the initiative so far. This is designed to provide formative feedback to inform the development of the initiative and share learning across practices. A more in-depth analysis of the impacts of the initiative will be undertaken for January 2015. At this time, the initiative will have been in place for approximately 11 months and summative feedback will be more appropriate.

### 3. METHODS

#### 3.1 EVALUATION AIMS AND OBJECTIVES

This evaluation aims to conduct a process and impact evaluation of the one-off funding of new graduate nurse employment in VLCA general practices. The objectives of the process evaluation are:

- To evaluate the implementation of the scheme by the VLCA practices, PHOs and DHBs,
- To evaluate the professional development support provided to new graduates nurses,
- Identify key learnings from the VLCA business owners and other stakeholders and
- Identify ideas for modifications and improvements to the scheme and its implementation.

The impact evaluation will evaluate the impact of the initiative on:

- Working relationships between the practices, PHOs and DHBs,
- Service delivery and patient care in general practice,
- The sustainability of VLCA practices,
- The workforce of the VLCA practices and
- The new graduate nurses' professional development and career decisions.

The methods used in the practice profiling, document analysis, and online stakeholder survey assist in the achieving of these objectives. These methods are described below.

#### 3.2 APPROACH

The evaluation draws on the principles of Realistic Evaluation (Pawson and Tilley, 1997).

Realistic evaluation looks for regularity in outcomes and mechanisms, but equally it looks to understand the role of context and explore differences. The approach seeks to understand how mechanisms (e.g. the implementation of the new graduate nurse funding) produce outcomes (both intended and unintended) under specific, contextual circumstances (e.g. variations in the spread of practice settings).

This type of evaluation is best implemented through a mixed methods approach. For the across site analysis the evaluation used practice profiling, document analysis and an online survey with key stakeholders from the VLCA practices, and their partnering Primary Healthcare Organisations and District Health Boards. These methods are described in more detail below.

### 3.3 PRACTICE PROFILING

Data was provided by the Ministry of Health in the form of: a PHO enrolment breakdown for 2013, New Graduate Nurse placements, and application forms of the VLCA practices participating in the NGN initiative. A google search was utilised to find the number of GPs that worked within each practice. Information from these sources was integrated into one practice profile spreadsheet to summarise the context within which the NGN initiative was being implemented. Specifically, practice level data was included for:

- Size of practice enrolments.
- Proportion of high needs enrolees.
- Proportion of Māori and Pacific enrolees.
- Age structure of enrolees.
- Deprivation index of enrolees.
- Size of the practice workforce.
- Whether a practice was a Māori or Pacific provider.
- Ethnicity, age and gender of the NGN.
- Previous training experience of the practice.

### 3.4 DOCUMENT ANALYSIS

An analysis of the application forms for the VLCA Sustainability Initiative was undertaken to provide an insight into the context of the different practices. This is important for understanding the types of practices involved in the initiative. Specifically, the documents were analysed to provide an insight into the ways in which the practices intended to:

- Address sustainability.
- Improve practice efficiency.
- Address the needs of high needs patients.
- Sustain the employment of the NGN.
- Provide support for the NGN at the practice.

### 3.5 ONLINE STAKEHOLDER SURVEY

The survey was designed to evaluate the process and implementation of the NGN role across the breadth of the VLCA practices, and to begin to explore the impact of the one-off funding scheme.



The online survey was designed to engage stakeholders from the practices, District Health Boards and Primary Healthcare Organisations involved in the initiative. At a broad level, the survey was designed to ask stakeholders to share their perspectives on:

- The application process and selection of the NGN
- Readiness of the practice for the arrival of the NGN
- Role of the DHB and PHO in implementation
- Support for the NGN
- Changes in the NGNs' skills and experience
- Impact of the NGN role at the practice
- Future intentions
- Sustainability of the role
- Key benefits, challenges and ideas for improvements

While the survey had some core questions that were answered by all stakeholders, there were specific sets of questions for different stakeholders. The NGN for example, was asked questions on the level of support for their role, which were not asked of the DHB and PHO staff. Business owners and practice managers were also asked about the impacts of the NGN on the business model and financials at the practice. This was designed to engage a broad range of stakeholder perspectives in the evaluation and also ensuring that the questions were relevant to the different stakeholder groups.

The survey was disseminated online using contact details provided through the application forms and provided to us directly from the Ministry of Health. The initial email invite was sent out on the 22<sup>nd</sup> of August 2014. This initial email was followed by a series of reminders designed to encourage participation. The survey remained in the field for six weeks.

When sending out the initial email invite, we had responses from the sector asking if they could send the survey on to others involved in the initiative. We were very grateful for this offer and then encouraged other stakeholders to do this same. This does make it difficult to calculate a response rate. The survey findings section identifies the number of stakeholders who completed the survey along with their roles.

### **3.6 ANALYSIS**

A descriptive analysis of the practice profiling data was used to describe the key characteristics of the practices involved in the Sustainability Initiative. This analysis supports the evaluation to

describe the practices, and inform the selection of practices for the second phase of the evaluation (see Section 8 for further information on the next phase of the evaluation).

The application forms from the VLCA practices that were successful in getting a NGN were analysed to validate the practice profiling data and to provide an insight into the intended implementation of the Sustainability Initiative at each practice. The open ended questions were analysed using open coding to identify key themes and patterns in the data.

The survey was analysed using descriptive statistics to provide an insight into the views and experiences of the key stakeholders involved in the new graduate nurse component of the VLCA Sustainability Initiative. When we found differences in the perspectives of different groups of stakeholders and providers we identify these in the report. It is important to note however, that these are emergent patterns in the data. The sample sizes for some of the different stakeholder groups were sometimes too small to support a statistical analysis. Subsequently, any differences noted in this report are not statistically significant.

## 4. VERY LOW COST ACCESS PRACTICES

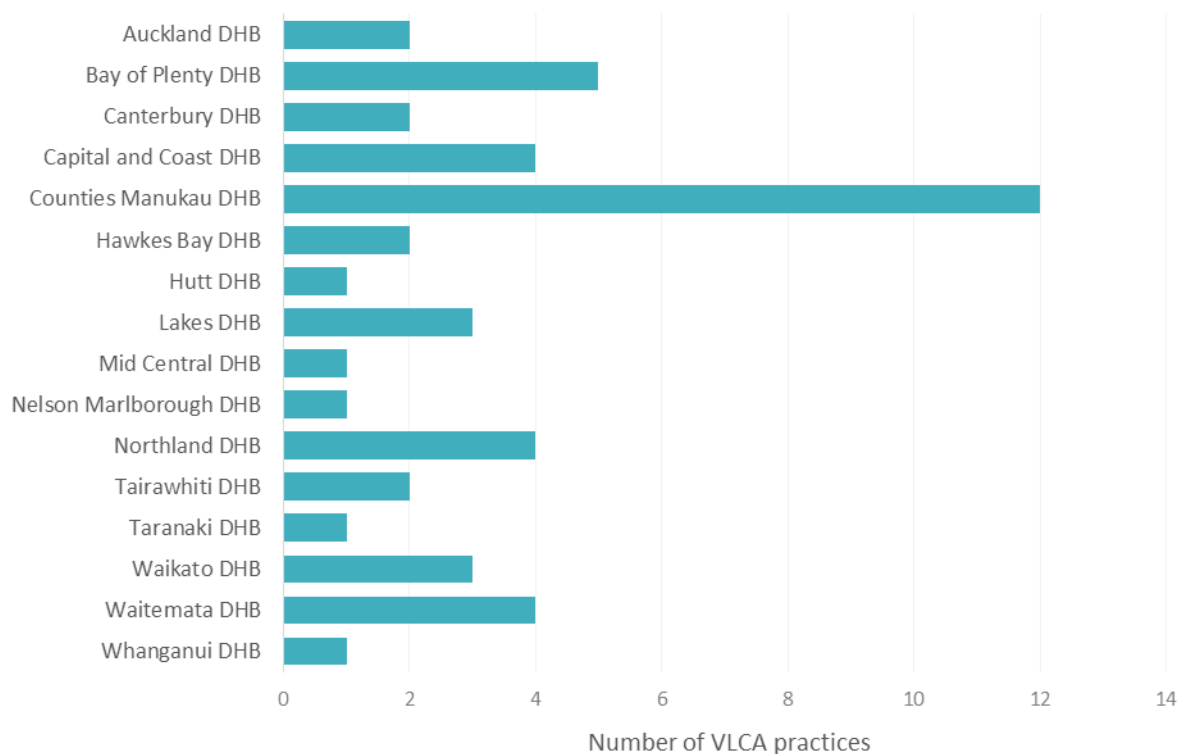
### 4.1 PRACTICE PROFILE

There were 48 VLCA practices<sup>1</sup> which were selected to receive funding for a NGN. This section focuses on the context of these 48 VLCA practices.

#### 4.1.1 Overview of the VLCA practices and their enrolled populations

A quarter of the VLCA practices with a NGN were located in Counties Manukau DHB (25% or 12 practices; Figure 1). Five NGNs were located within the Bay of Plenty DHB, and Capital and Coast, Northland and Waitemata DHBs all had four NGNs.

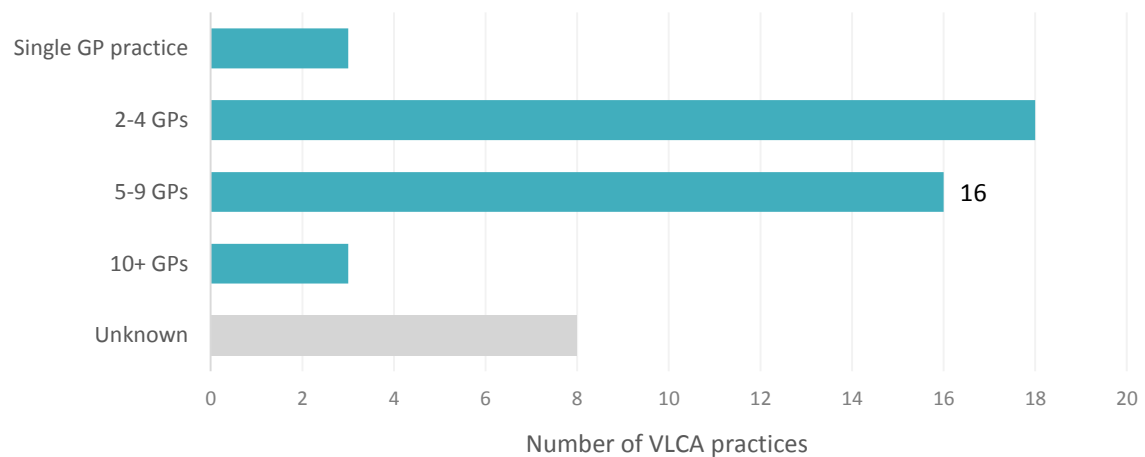
**Figure 1: DHB of the VLCA practices (n=48)**



Most of the VLCA practices had between 2 and 9 GPs, with 38% of practices having 2-4 GPs (18 practices) and 33% having 5-9 GPs. Only 6% were single GP practices (3 practices) and 6% had more than 10 GPs (3 practices; Figure 2).

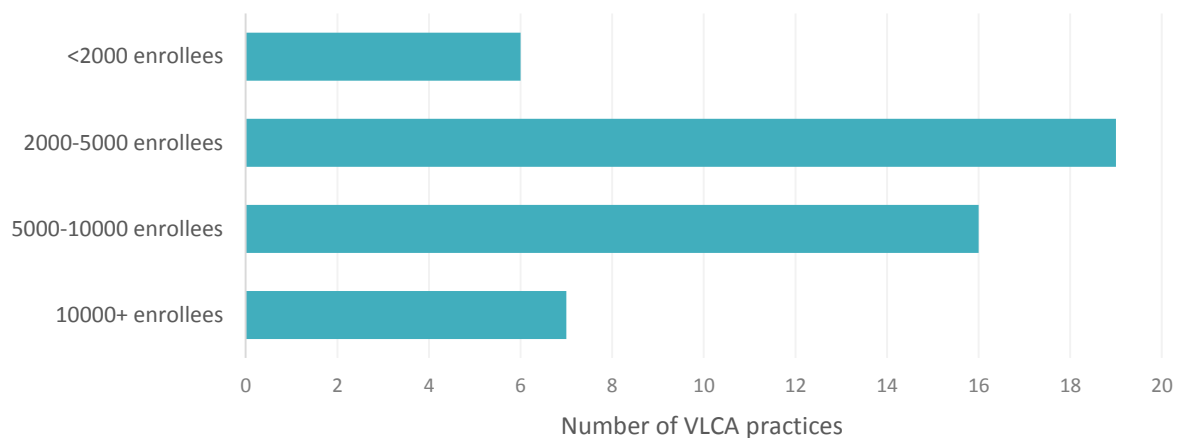
<sup>1</sup> Note that some of the VLCA practices are multi-site practices (i.e. more than one physical location). However these practices functionally operate as one practice, sharing staff and resources, so for the purposes of this analysis they have been considered one practice

**Figure 2: Number of GPs per practice (n=48)**



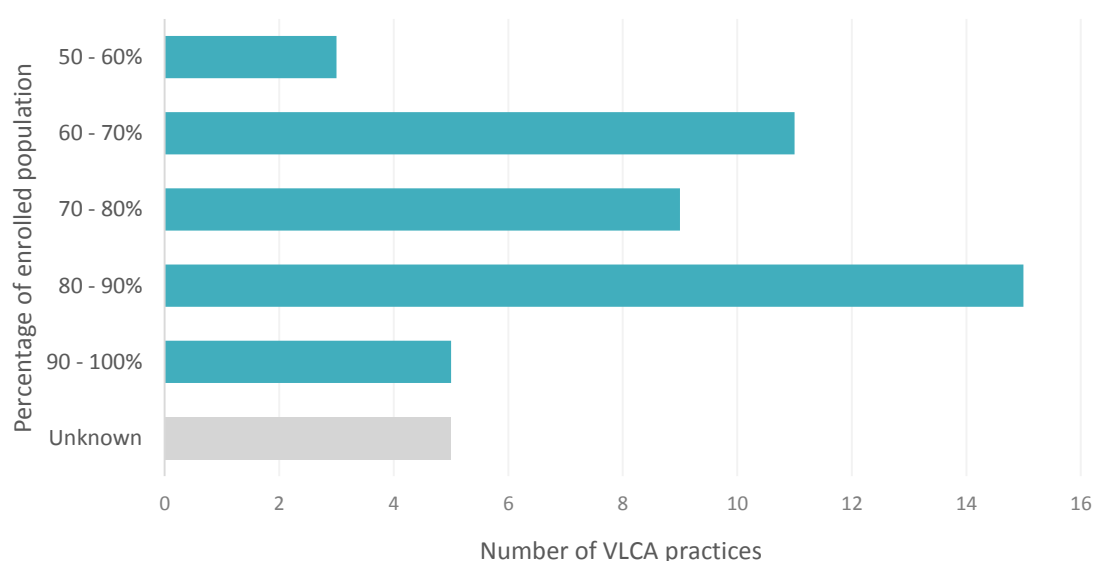
Two-fifths of the VLCA practices had an enrolled population of between 2,000 to 5,000 patients (40% or 19 practices), and a third of practices had between 5,000 and 10,000 enrolled patients (33% or 16 practices; Figure 3).

**Figure 3: Size of enrolled population per practice (n=48)**



As per the VLCA requirements, practices receiving additional funding or one-off funding for a new graduate nurse had 50% or higher enrolled populations classified as high needs. Two-fifths of the VLCA practices had a very high proportion of high needs enrolled population, with 20 of the 48 practices having over 80% of their patients in this group (Figure 4).

**Figure 4: Proportion of enrolled population characterised as high needs (n=48)**



There was a fairly even spread of enrolled Māori population at the practices involved in the initiative - around a third of practices had less than 30% Māori, a third had between 30-60% Māori, and a third had more than 60% of their enrolled population identifying as Māori. One of the VLCA practices has more than 90% of their enrolled population identifying as Māori.

Almost half of the VLCA practices had less than 10% of their population identifying as Pacific (46% or 22 practices). Seven of the practices in the initiative have high Pacific enrolled populations, with more than 70% Pacific patients, and two practices have more than 90% of their patients identifying as Pacific.

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#### 4.1.2 Experience with students and new graduates

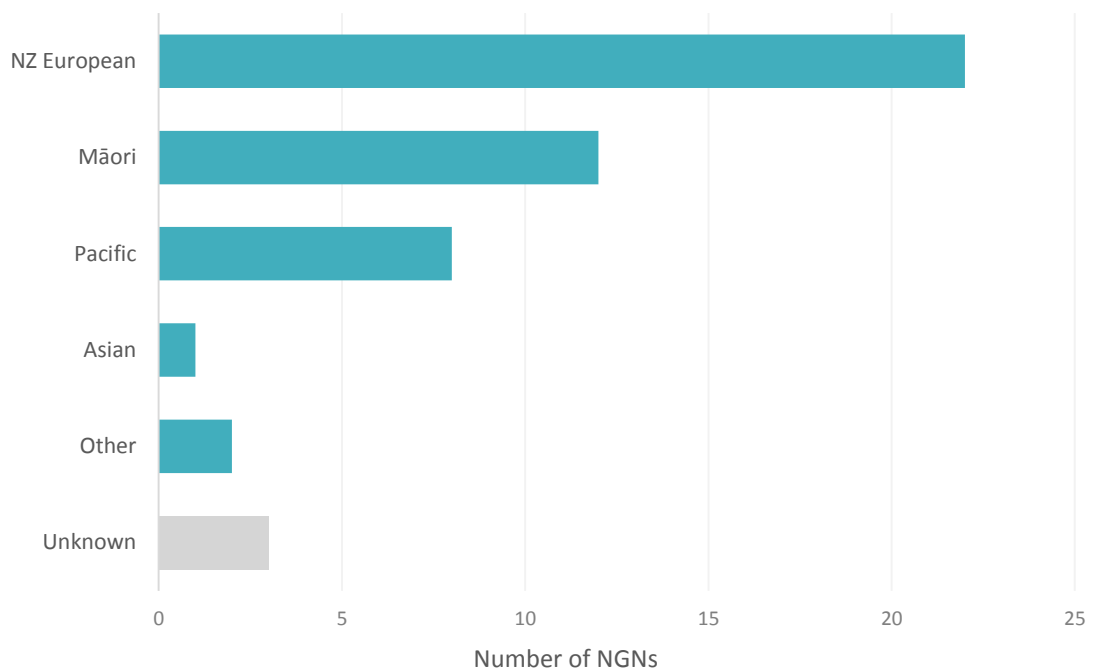
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Of the 48 VLCA practices, ten had previously employed a new graduate nurse before the VLCA initiative took place (21%). Eleven practices had previously taught a medical student or a nursing student (23%), and of those, five practices had previously taught both (10%). Only two of the practices had previously employed a new graduate nurse and taught both medical and nursing students (4%).

## 4.2 NEW GRADUATE NURSE PROFILE

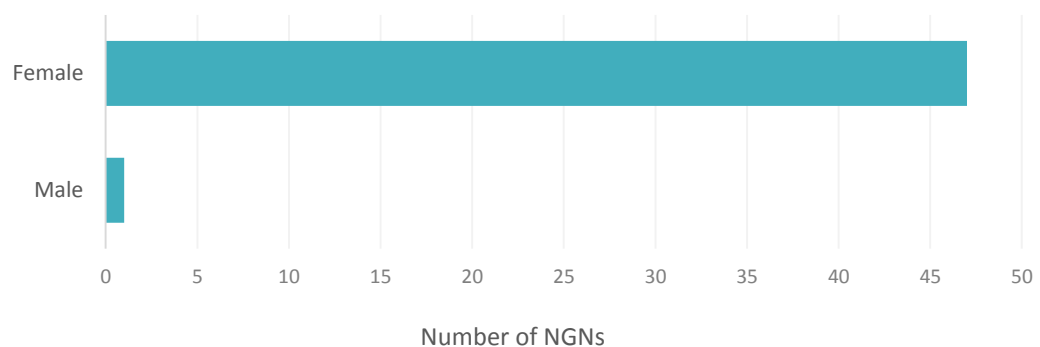
The VLCA initiative provided funding for 48 New Graduate Nurses. Almost half of the NGNs involved in the initiative identified as NZ European (46% or 22 NGNs). A quarter identified as Māori (25% or 12) and 17% identified as Pacific (8 NGNs; Figure 5).

**Figure 5: Ethnicity of the New Graduate Nurses (n=48)**



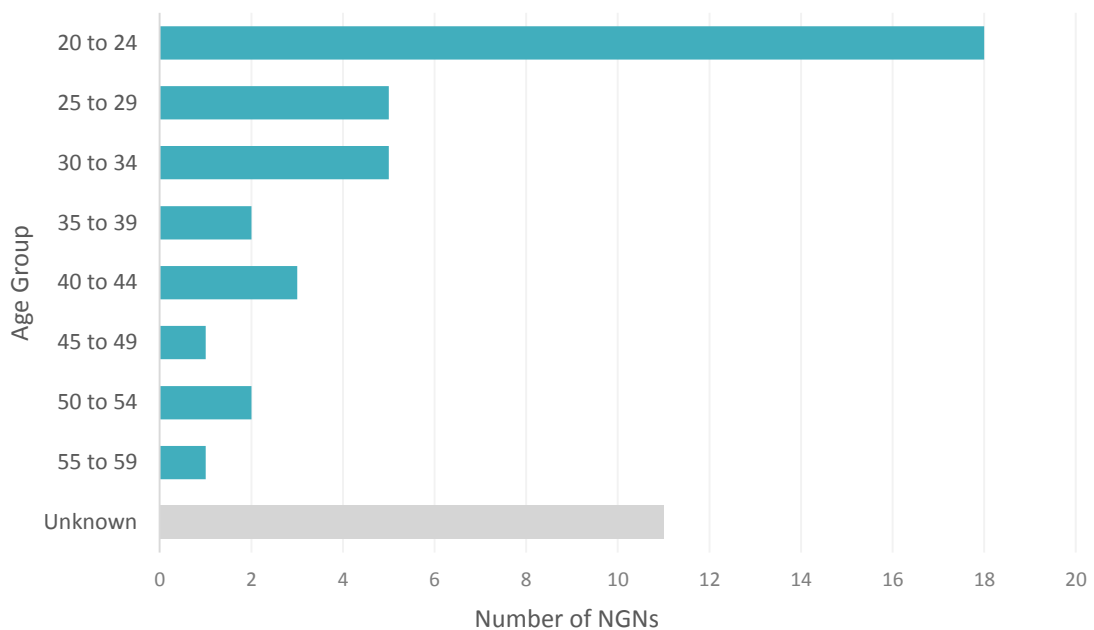
All except one of the NGNs employed by the VLCA practices for the Sustainability initiative was female (Figure 6).

**Figure 6: Gender of New Graduate Nurses (n=48)**



Almost half of the NGNs involved in the initiative were between 20 and 30 years of age (48% or 23 NGNs). A quarter were aged between 30 and 50 years (23% or 11 NGNs), while 6% of the NGNs were over 50 years of age (3 NGNs; Figure 7)

**Figure 7: Age Group of New Graduate Nurses (n=48)**



#### **4.3 SUMMARY**

The one-off funding for the NGN reached 48 VLCA practices across New Zealand. Most of these practices had at least two GPs at the practice. The majority of practices had an enrolled population between 2,000 to 5,000; and over 80% of this enrolled population classified as high needs for most of practices.

Most of the practices had not had a NGN at their practice before. In terms of the NGNs characteristics, roughly half were NZ European, a quarter were Māori and 17% were Pacific. Most of the NGNs were aged between 20 and 24, and were female.

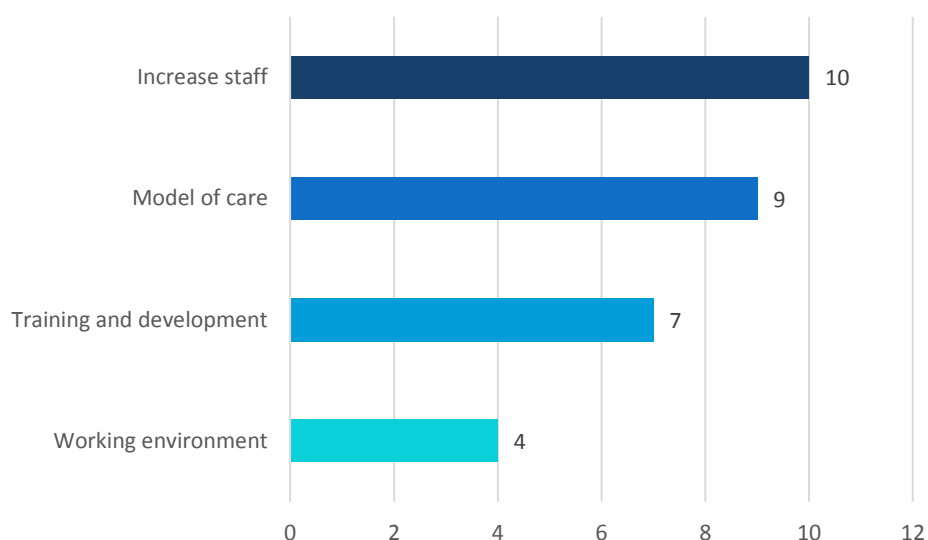
## 5. INTENDED IMPLEMENTATION

Analysis of the application forms of the VLCA practices that were successful in getting a new graduate nurse demonstrated how the practices intended to implement changes. These intentions are divided into different categories closely aligned to the questions in the document. These categories are intentions to address: workforce sustainability, practice sustainability, practice efficiency, ability to address high needs clients, long-term employment for their new graduate nurse, support for their new graduate nurse, and relationships with PHOs and DHBs. As the application forms were integrated with the VLCA sustainability funding, the responses were not specific to only the funding from the one-off funding for employing a new graduate nurse.

### 5.1 WORKFORCE SUSTAINABILITY

Practices were asked how they would support the workforce sustainability of the practice. Responses involved a variety of themes shown below in Figure 8.

**Figure 8: Key approaches to addressing workforce sustainability**



The most common response was to **increase the number of staff** in the practice. This included having more staff from the addition of the NGN but also included being able to recruit extra positions such as: a new GP, part-time psychologist, part-time practice manager, and a Long Term Conditions nurse.

Nine practices indicated that they would transition to a **nurse-led model of care** to support workforce sustainability. This is evident by the response from one of the practices:



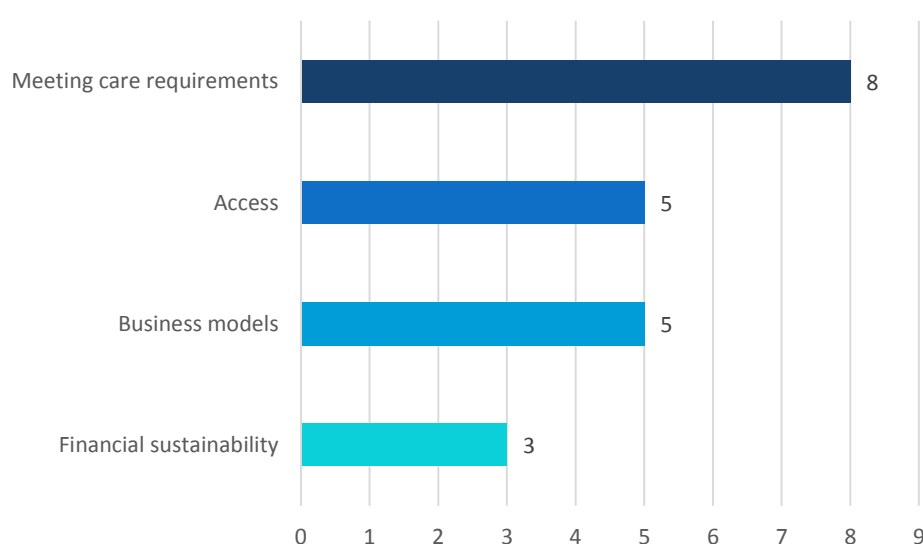
*“Building nursing workforce and model of care that overtime can transition from a GP led service to a nurse led service.”*

**Training and development** was mainly discussed in terms of existing clinical staff getting the time to be released for training as well as funding for training. Improving the **working environment** included improving the clinic environment as well as providing permanent employment rather than contracts.

## 5.2 PRACTICE SUSTAINABILITY

Practices were asked how they would support the sustainability of the practice. Responses are summarised in Figure 9 where the main responses relate to providing quality care with a smaller focus on financial sustainability.

**Figure 9: Key approaches to addressing practice sustainability**



**Meeting care requirements** involves meeting patient needs by: practicing a Whānau centred model of care, developing patient-centred care planning, triage monitoring, extending consultation, developing plans to meet long-term needs and refugee needs. Meeting health targets was also included here as it contributes to improved care for the population. Meeting health targets also has some financial sustainability implications as some funding is tied to performance of these targets.

*“The employment of a New Graduate will enable more nurse-led services to be developed with an increased emphasis on achieving and exceeding the health targets.”*

Quality healthcare also involves providing **access** to care and this emerged as a key theme for the way practices would approach sustainability. Specifically the practices mentioned: continuing to provide low-cost access, offering more services, increasing access to preventative care, extending practice hours, and providing innovative transport strategies.

**Business models** were considered relevant to ensuring practice sustainability. These were mentioned in terms of testing models of sustainability, new models of delivery in partnership with their PHO, and conducting a business model review:

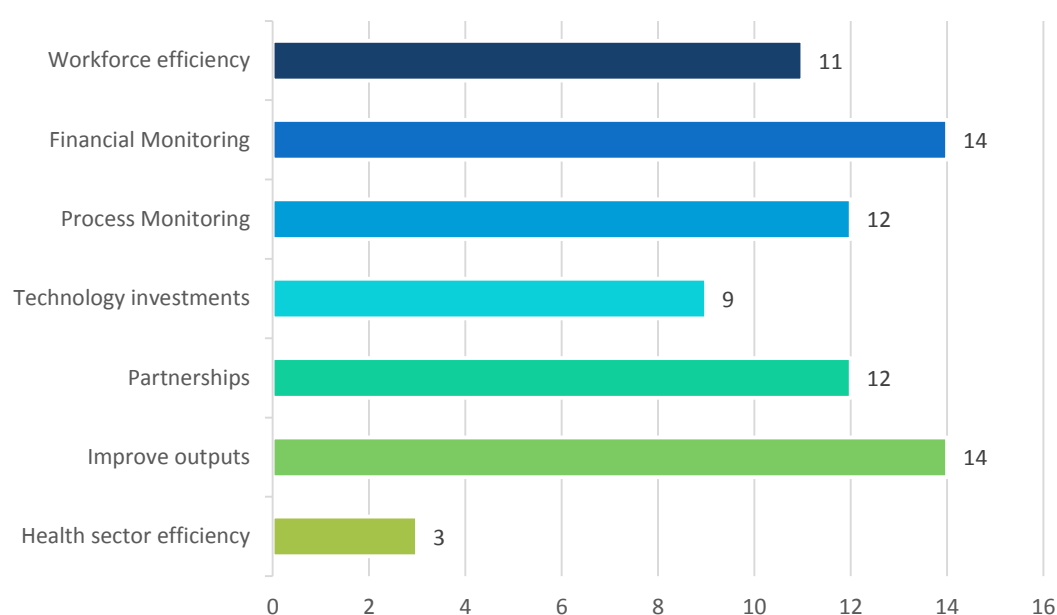
*“Business model review to identify areas where income can be maximised. Additional administration training to determine the amount of debt which will never be paid, processes that improve reconciliation of accounts and maximise funding/claiming streams.”*

Only three practices explicitly mentioned using the initiative to support **financial sustainability**, although the role of the initiative in supporting financial sustainability more frequently identified when asked about practice efficiency in the application form.

### 5.3 PRACTICE EFFICIENCY

Practices were asked what they were doing to ensure optimal efficiency of the business. A range of actions towards ensuring optimal practice efficiency arose from the VLCA practice applications (Figure 10). The most common actions involved financial monitoring and improving outputs.

**Figure 10: Key approaches to supporting practice efficiency**



**Financial monitoring** included: regular reviews of financials, decreasing costs, monitoring income, continuous quality improvement in the financial area, and working with a financial advisor. Regular reviews of financials was the most commonly stated action. One application stated they had:

*“Financial management practices - annual budget approved by board. Revenue Maximisation. Expense management. Monthly financial reporting. External audit.”*

**Improving outputs** included: use of data to monitor access, supporting their model of care, a service integration plan, and implementing recommendations from a review. Supporting the delivery of their model of care was the most commonly stated action.

**Process monitoring** involved: having a coherent strategic plan, working on inefficiencies, continuous reviews of systems and processes, as well as PDSA cycles for business and clinical models. Reviewing systems and processes was often cited, with nine practices intending to conduct review:

*“Constant review of practice culture, healthcare environment, initiatives and impacts. Regular needs analysis and response planning. Regular review of performance indicators. Engagement in change forums and pilot initiatives.”*

*“All clinical staff are required to continually review processes and systems.”*

**Partnership** actions were diverse and could involve: being supported by their PHO, achieving economies of scale with other practices, integration with secondary care, merging with a social services provider, benchmarking with other clinics, and positioning as a teaching practice. The most common approach to partnership involved support from their PHO:

*“The practice is supported by [PHO] that provides education, business intelligence, business owner forums. Practice manager forums.”*

**Workforce efficiencies** included; the use of medical assistants, performance reviews, changing the way staff are used, and ensuring that existing staff are working at the top of their scope. All were mentioned relatively equally. One practice illustrated the way they were using their workforce to ensure efficiency:

*“Up skill and increase the capacity of our 3 healthcare assistants, and registered nurse.”*

**Technology investments** included getting new technology, upgrading or replacing existing technology, and improving IT systems. Technology ranged from equipment to provide extra diagnostic services to “virtual consults” and “auto check in.”

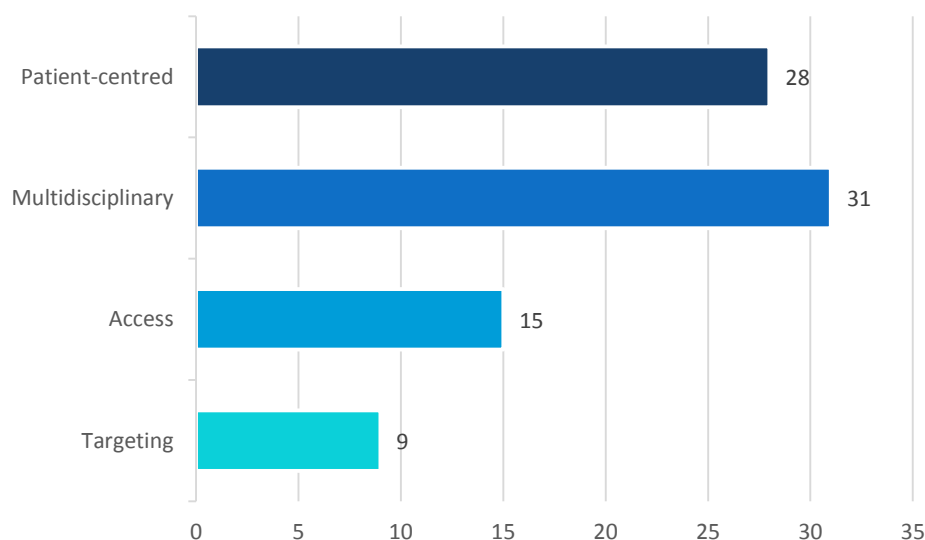
Three practices made comments that indicated they were thinking about **health sector efficiency**. One such practice commented that:

*“As well as being proactive in prevention of hospitalisation, [practice] offers the same day urgent care appointments with the savings extending to patients, hospitals, and ambulance services.”*

#### 5.4 ABILITY TO ADDRESS HIGH NEEDS CLIENTS

Practices were asked how their model of care would address the high needs of their enrolled population.<sup>2</sup> Most responses indicated a model of care that was multidisciplinary or patient-centred, other responses alluded to targeting and encouraging easy access (Figure 11). Multidisciplinary and patient-centred models of care were the most common responses and many practices used a combination of actions to address their high needs patients.

**Figure 11: Key approaches to addressing the high needs of their enrolled population**



A **multidisciplinary** model of care reflected practices intentions to: adopt a multidisciplinary approach, increase links with health and other social services, or being an Integrated Family Health Centre (IFHC). A multidisciplinary approach and linking with other health and social services were both mentioned by 17 practices and only four mentioned that they assumed an IFHC model.

<sup>2</sup> Answers to this question were more broad than the VLCA definition of high needs (Maori, Pacific and Quintile 5) including initiatives and programmes such as chronic care, nurse led care, alternative care etc.

A **patient-centred** model of care included: increasing health literacy and self-management (sixteen practices), Whānau centred service (fifteen practices) and providing additional resource for prevention messages (thirteen practices):

*“The team’s vision is to go from being opportunistic to undertaking preventative care, and, ultimately helping to develop the health literacy<sup>3</sup> in the community.”*

Encouraging **easy access** included: maintaining low-cost access, opportunistic care, home and community services, ethnic-based services, health messages in different languages and interpreter services. Opportunistic was most frequently noted:

*“Opportunistic care involving all of the primary care team including – Receptionist, Clinical Assistants, Nurses, Pharmacists, Psychiatrist, Psychologists, GPs and Clinical Navigators.”*

**Targeting services** included: additional resources into hard to reach populations, tools to identify risks and disease, and targeting funding to highest needs patients. Putting resource into hard to reach populations was most common with seven practices indicating they would be doing this to address the needs of their high needs patients.

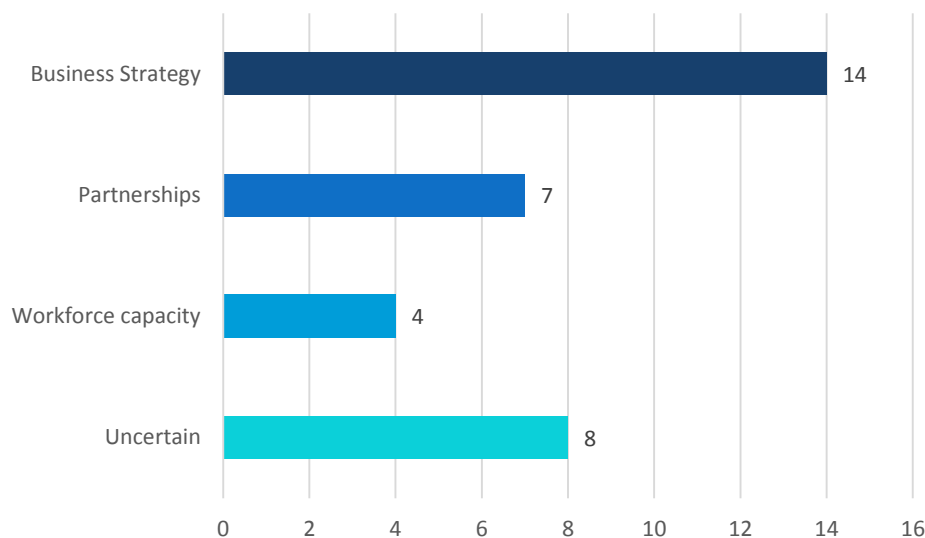
## 5.5 NEW GRADUATE NURSE EMPLOYMENT

Practices were asked how the sustainability of the NGN employment would be ensured after the one-off funding ended in 12 months. The majority of responses indicated that they had a business related strategy that would ensure sustainability of the role as shown in Figure 12. Other themes included: working with partners to ensure sustainability of employment, workforce capacity for the NGN to continue, and others that indicated they were unsure if employment would be sustainable.

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<sup>3</sup> The Ministry of Health acknowledges that improving health literacy is a responsibility of health policy makers, planners and providers, as well as communities.

**Figure 12: Key approaches to supporting the ongoing employment of the NGN**



There were a variety of **business strategies** mentioned for sustaining the NGN after the twelve months of government funding. Increasing enrolments was the most frequently stated strategy with 5 practices mentioning this on their application. Other strategies included changing the model of care, securing more funding, and locality plans<sup>4</sup> to help with sustainability. Planned changes to the model of care or delivery of services included:

*“With the support of the VLCA sustainability funding the practice will strengthen its ability to offer more nursing services that are funded (e.g. CarePlus, cervical smears, PPP targets, DCIP) which will decrease the reliance of patient payments and improve the viability of the practice.”*

**Partnership** approaches to sustaining the NGN at the practices related to four key subthemes:

- An agreement with another practice to share employment ongoing.
- Taking actions to find employment in another VLCA practice if employment can’t be sustained.
- PHO dedicated to finding employment in another practice if employment can’t be sustained.
- Combined practice and PHO effort to ensure sustainability of NGN employment:

*“[PHO] will endeavour to ensure continued employment within a ... practice as the benefits of being trained in the [PHO] model of care, the on-line tools to support achievement of the*

<sup>4</sup> Locality planning aims to co-ordinate primary, hospital, public health and community services at the local level of the patient in order to place local communities at the heart of how health services are planned and where and how they are delivered.

*quality plan & health outcomes, make the graduate nurses a valuable resource to retain within the network.”*

The partnership to sustain NGN employment across practices is evident by the response:

*“The practice has entered into an arrangement with another [practice within the PHO] and between them they will be able to offer the nurse long term employment after the completion of the new graduate funding.”*

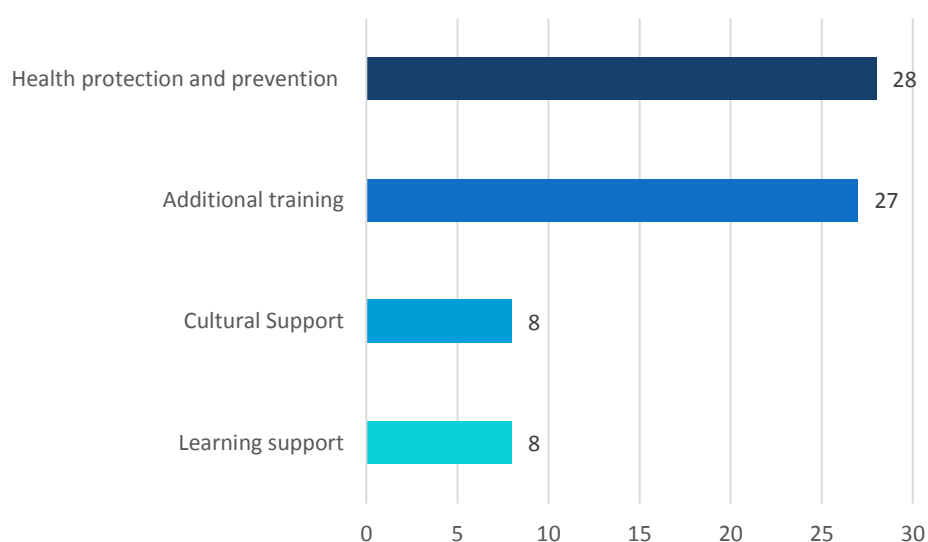
**Workforce capacity** to sustain the employment of the NGN included the intentions to employ the NGN as a result of either: staff turnover, workforce development, or ability to absorb NGN into the current workforce structure.

Some practices were **uncertain** as to how the employment of the NGN would be sustained at the time of the application. These practices noted that: they were unsure if a position would be available, they would require more funding, or it would depend on the nurse’s performance.

## 5.6 NEW GRADUATE NURSE SUPPORT

In the applications, practices were asked how the DHB, PHO and practice intended to support the NGN over the twelve month initiative. All applications included a reference to the NETP programme. Other support they intended to provide is illustrated in Figure 13.

**Figure 13: Key approaches to providing support for the NGN**



Training in **health protection and prevention skills** were mentioned in 28 applications. This included: vaccinator training, smear training, and cannulation training, sexual health training, Long Term Conditions training, smoking cessation training, and diabetes training.

Several of the practices also noted the role of **additional training**. This included training and education provided by the DHB and PHO. One PHO documented their education plan on all applications in which they were involved:

*“- 6 CNE sessions across all localities.*

*- Practice Nurse peer support group meetings*

*- Training on specific activities within the LTC Management Program.*

*- Training to support the introduction of new technology and information tools.*

*- Training to support achievement of goals and targets within our quality programme.*

*- Clinical skills development.*

*- PDRP coaching and support.”*

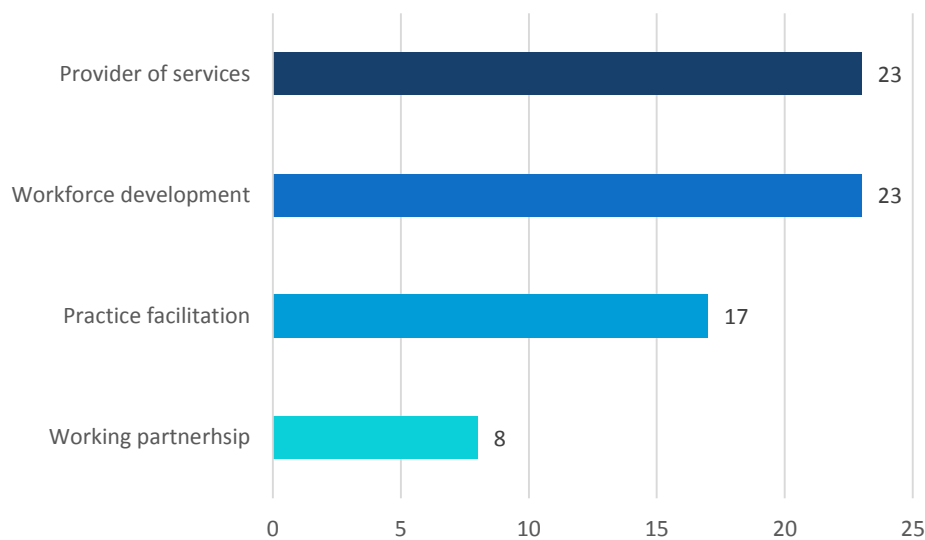
**Cultural support** and **learning support** was also mentioned by some practices, although less frequently. Cultural support involved supporting cultural competencies as well as familiarisation with Kaupapa Māori values and providing a connection to local iwi. Learning support included E-learning, Professional Development and Recognition Programme support, and a personal development plan.

## **5.7 RELATIONSHIP WITH PHO AND DHB**

The application form also required information on what experience, skills and expertise the PHO and DHB would apply in partnership to build capacity and capability in the VLCA practice. This provided some insight into the type of relationship they expected to have through the initiative. These approaches fell into four general themes (Figure 14).



**Figure 14: Key approaches to providing practice support from DHB and PHO**



A **provider of services** reflected the role of the DHB or PHO in providing a specific support or service for the practice. This included: clinical leadership and governance, a business advisor, quality improvement feedback, monitoring and reviewing of practice performance, and assisting with the practice model of care:

*“Support feedback on progress from quality improvement team. Locum support. Professional development opportunities. New model leadership. Policies and guidelines. Project management support.”*

**Workforce development** is a separate theme as a lot of the intended support from DHBs and PHOs was specific to developing the health workforce. Key supports included: training and education, upskilling, cultural supervision, appropriate specialist support, and one application mentioned locum support.

**Practice facilitation** reflects the role of the DHB and PHOs in building the capacity of the practices. This included: sharing best practice, sharing information, providing access to information and technology to support the initiative.

A **working partnership** was where some of the applications were more ambiguous. Some suggested that they would be working together without specifying the nature of the relationship. This is reflected in comments such as “partnering agreement,” “collaborative work plan,” and one response which stated that the practice, PHO and the DHB already work closely across a range of issues and would continue to do so.

## 5.8 SUMMARY

The application forms provided a valuable insight into the intended implementation of the VLCA Sustainability Initiative. It is important to note that these intended approaches and impacts also reflect the broader funding available to the VLCA practices, as well as the NGN role. This evaluation seeks to provide an insight into the implementation and impacts of the one-off funding for the NGN.

In terms of this component of the initiative, the applications have identified the role of the NGN in supporting an increased focus on nursing care at the practice. The applications also identified the range of approaches that the practices intended to use to support the NGN. This often included support from the DHB through the NETP programme, as well support from existing practice staff and providing specific training.

Sustaining the employment of the NGN role was often associated with intentions to increase enrolments, although opportunities for growing the practice through the wider VLCA initiative and supports from the DHB and PHO were also often cited. Some of the practices also acknowledged that the continued employment of the NGN was uncertain at the time of the application. The practices did offer some interesting ideas for sustaining the role. This included partnering with other practices and or their PHO to sustain the role.

## 6. UNDERSTANDING CURRENT IMPLEMENTATION AND IMPACTS

### 6.1 PROFILE OF SURVEY RESPONDENTS

Overall, there were 171 responses to the New Nurse Graduate evaluation stakeholder survey.

- 117 responses were from Practice Staff across 42 of the 48 practices
- 22 responses were from PHO staff across 17 of the 26 PHOs involved in the initiative
- 32 responses were from DHB staff across 13 of the 16 DHBs involved in the initiative

*Note: The survey was fully anonymous and it was possible for respondents to answer the survey multiple times (though they were not encouraged to). During the analysis phase, obvious duplicate responses were removed; however there were 32 responses from NGNs across only 30 practices. It is possible that the additional 2 responses were from new graduates who weren't part of the initiative, or they may be duplicates which could not be removed. Because of this all survey results will be reported based on the role of the participants rather than down to the specific practice level.*

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#### 6.1.1 Role of Respondents

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NGNs were more likely to complete the survey than other stakeholders, representing almost a fifth of all respondents (19%; Table 1). Practice Managers (18%), PHO Staff (13%) and Other DHB staff (12%) were the next most common respondents. Business/Practice Owners were less likely to complete the survey, representing 5% of the total.

**Table 1: Survey respondents by role**

Role	Number	Percentage
New Graduate Nurse	32	19%
Nurse Preceptor	19	11%
Practice Nurse	16	9%
Other Practice Staff	11	6%
Practice Manager	30	18%
Business/Practice Owner	9	5%
PHO Staff	22	13%
NETP coordinator	12	7%
Other DHB Staff	20	12%
<b>Total</b>	<b>171</b>	

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### 6.1.2 DHB of respondents

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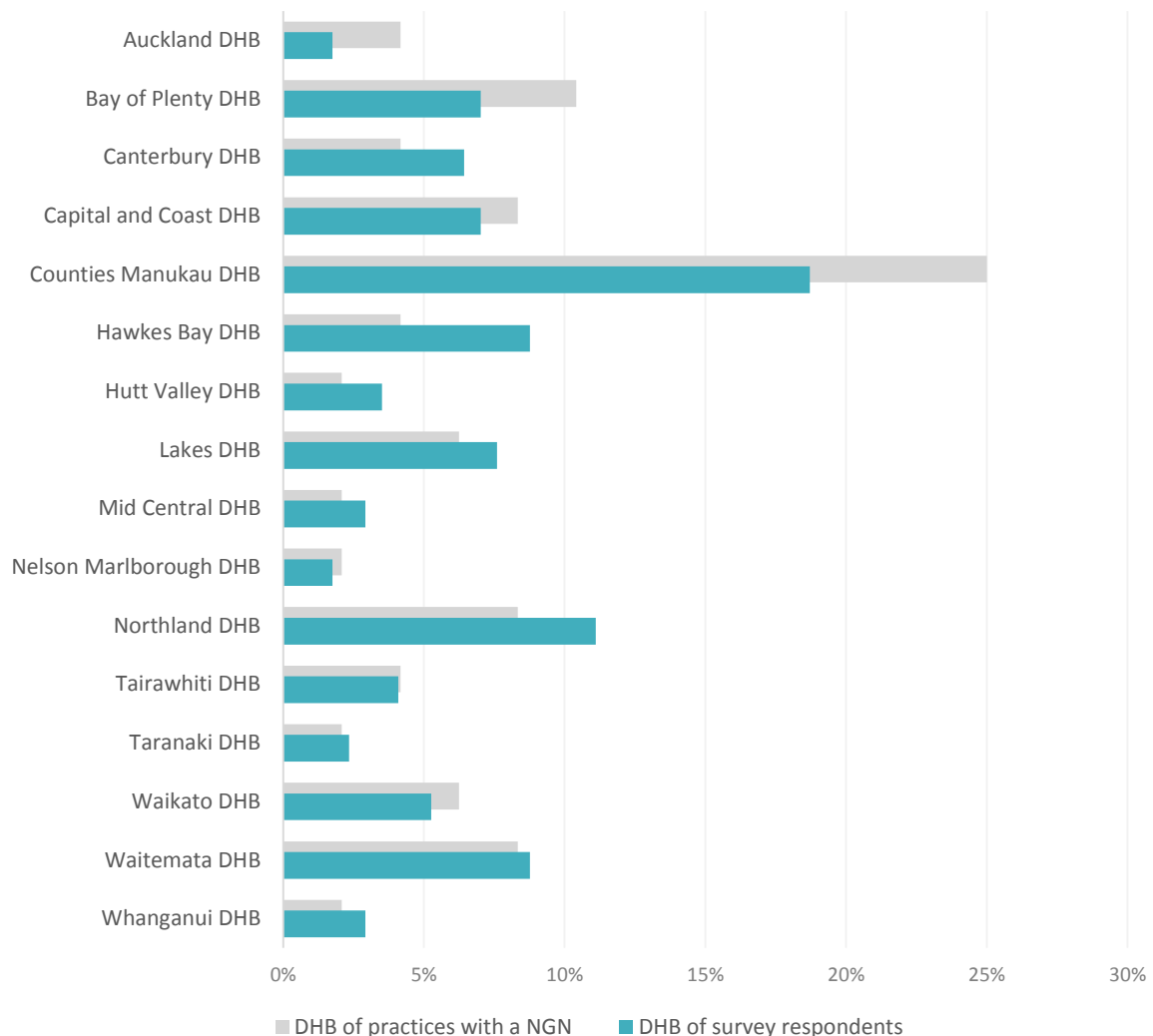
Almost a fifth of survey participants were from the Counties Manukau DHB region (19%). Just over a tenth of respondents were from Northland DHB (11%; Table 2). The upper North Island (Northland, Auckland, Waitemata, and Counties Manukau) represented approximately 40% of all survey respondents.

**Table 2: Survey respondents by DHB**

DHB of All Respondents	Number	Percentage
Auckland DHB	3	2%
Bay of Plenty DHB	12	7%
Canterbury DHB	11	6%
Capital and Coast DHB	12	7%
Counties Manukau DHB	32	19%
Hawkes Bay DHB	15	9%
Hutt Valley DHB	6	4%
Lakes DHB	13	8%
Mid Central DHB	5	3%
Nelson Marlborough DHB	3	2%
Northland DHB	19	11%
Tairāwhiti DHB	7	4%
Taranaki DHB	4	2%
Waikato DHB	9	5%
Waitemata DHB	15	9%
Whanganui DHB	5	3%
<b>Total</b>	<b>171</b>	

The geographical distribution of survey respondents was relatively similar to the number of practices with a NGN in each of the DHBs. Canterbury, Hawkes Bay, Northland, Hutt Valley, Lakes, Mid Central, Waitemata and Whanganui DHBs had proportionally more respondents, in comparison to the number of VLCA practices with a NGN in the DHB (see Figure 15).

**Figure 15: Comparison of DHB of survey respondents (n=171) vs the number of VLCA practices with an NGN in each DHB (n=48)**

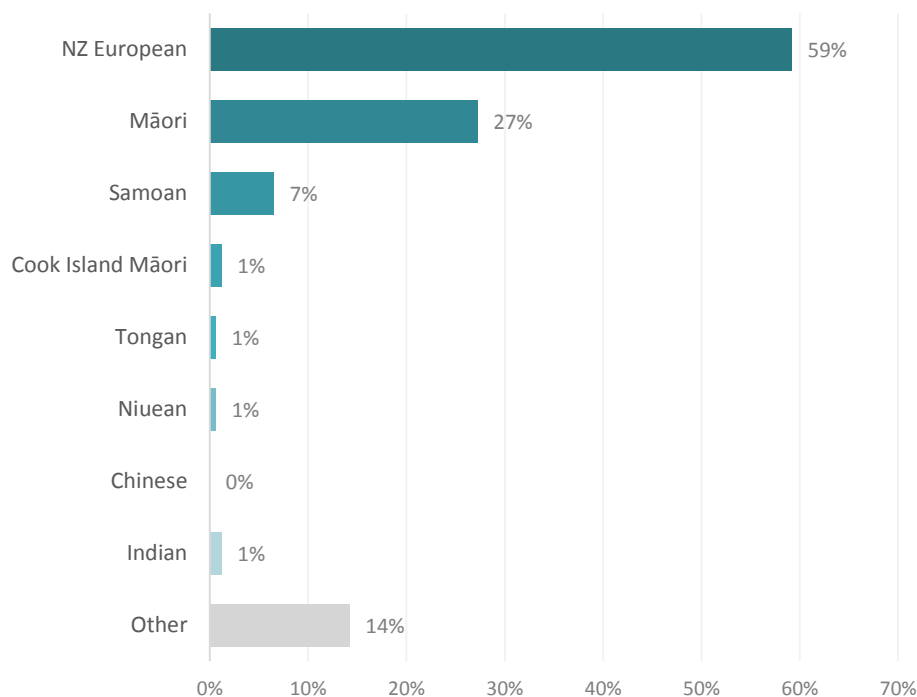


### 6.1.3 Ethnicity of respondents

Almost two-thirds of respondents identified as NZ European (59%)<sup>5</sup>. Over a quarter identified as Māori (27%) and 10% identified as Pacific People (7% Samoan, 1% Cook Island Māori, 1% Tongan and 1% Niuean). The 'Other' category represented 14% of respondents and mostly consisted of non-NZ Europeans such as British, Irish and Australian (Figure 16).

<sup>5</sup> Respondents were able to identify multiple ethnic groups when describing their ethnicity. This summary reports all of the ethnicities identified by the respondents when completing the survey.

**Figure 16: Ethnicity of survey respondents (n=169)**



## 6.2 APPLICATION PROCESS AND NURSE SELECTION

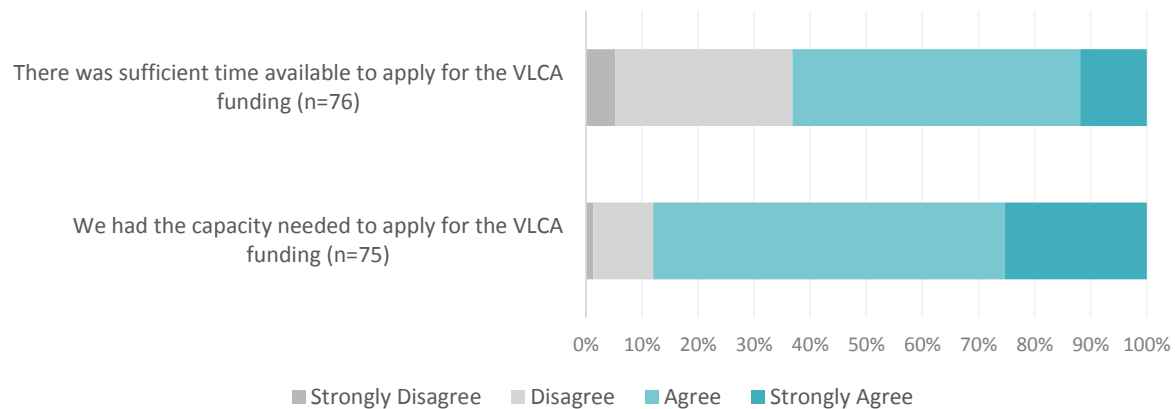
Every survey respondent except for the NGNs was asked if they were involved in the application for the VLCA funding. Of these respondents, three-fifths (60%) were involved in the application process to some degree.

Unsurprisingly, Practice Managers and Owners, and DHB staff were most likely to have been involved in the application process, followed closely by DHB staff. Nurses and other practice staff were less likely to have been involved in the process.

**Almost two-thirds of respondents involved in the process thought there was sufficient time available to complete the application for VLCA funding (63% agree and strongly agree; Figure 17).** Practice staff who were involved in the application process were more likely to think there was sufficient time, while DHB staff in particular thought there wasn't sufficient time.

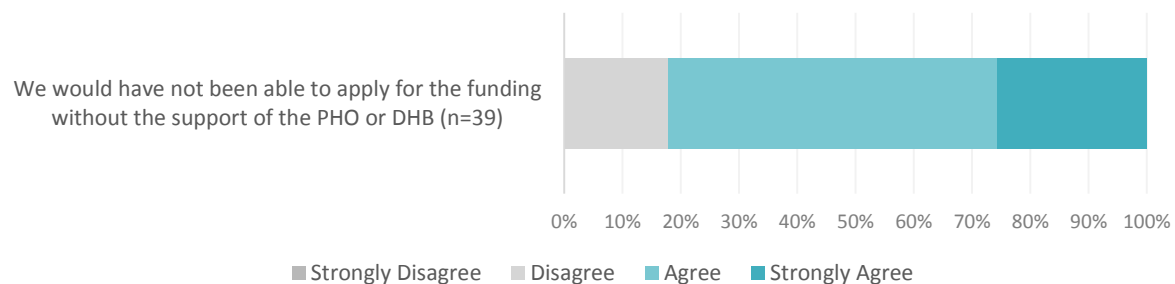
Almost all respondents thought there was sufficient capacity to complete the application process (88% agree or strongly agree), with little difference between the respondents' roles.

**Figure 17: Time and capacity available for the VLCA application [all respondents involved in the application]**



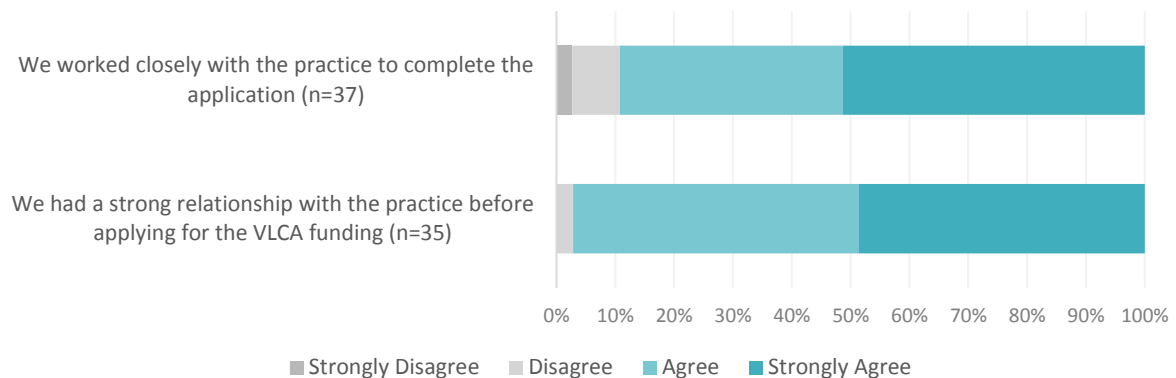
Almost all of the respondents working in a VLCA practice agreed or strongly agreed that they required the support from the PHO or DHB to complete the application process (88%; Figure 18). Practice Managers were the only role who disagreed with this statement, with 28% (7 practice managers) indicating they could have completed the application without the PHO or DHB.

**Figure 18: Support from PHO or DHB [Practice respondents involved in the application]**



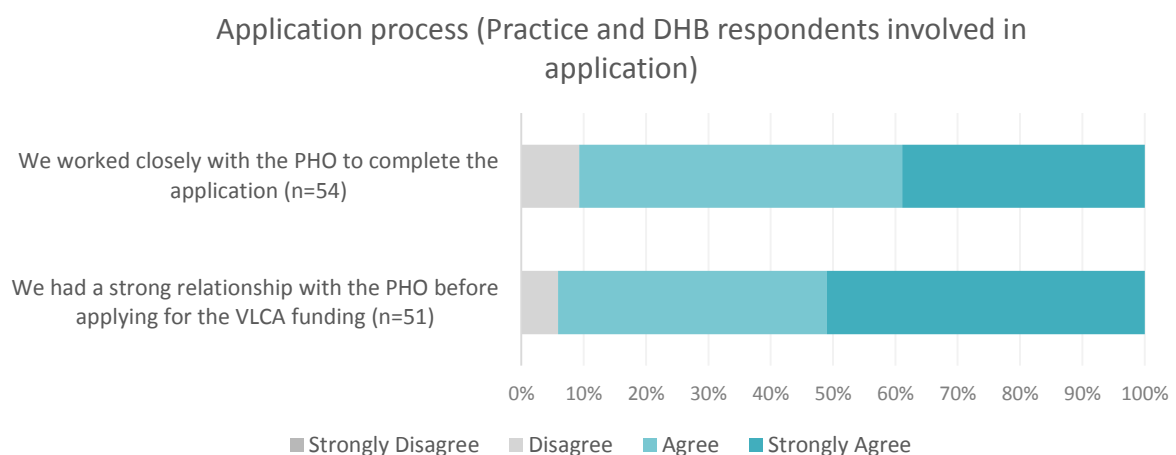
The vast majority of DHB and PHO respondents indicated that they worked closely with the practices during the VLCA application process (89% agreed or strongly agreed), with no major difference between the PHO and DHB respondents (Figure 19). All but one respondent agreed that they had a strong relationship with the VLCA practice before applying for funding (97%).

**Figure 19: Relationship with the practice during the application [PHO and DHB respondents involved in the application]**



Almost all Practice and DHB respondents indicated that they worked closely with the PHO to complete the VLCA funding application (97%) – with only a small group of Practice Managers disagreeing (Figure 20). A similar pattern was evident when respondents were asked if they had a strong relationship with the PHO before undertaking the application process, with 94% of respondents agreeing, and only a small group of Practice Managers disagreeing.

**Figure 20: Relationship with the PHO during the application [Practice and DHB respondents involved in the application]**



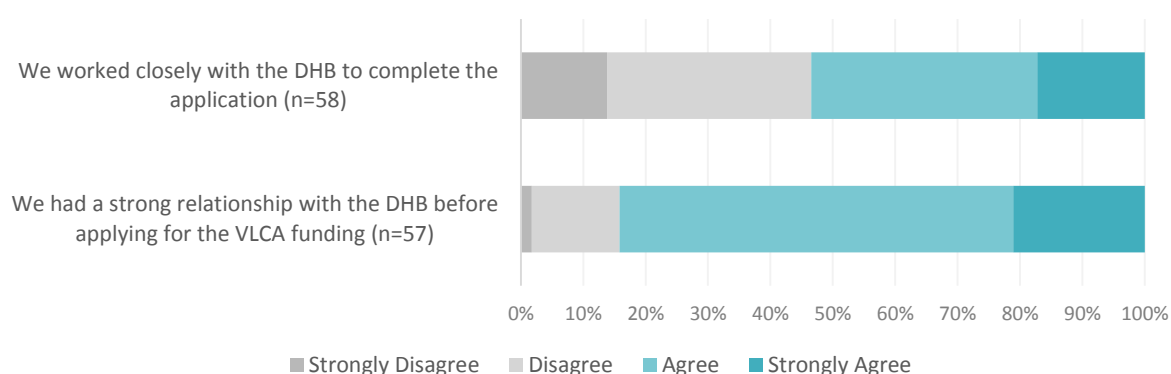
Overall, Practice and PHO respondents were less positive when asked if they worked closely with the DHB during the application process (Figure 21). Compared to the previous questions, just over half of



respondents agreed with the statement (53%). Most of this disagreement was due to respondents working at the VLCA practices, with only a third of agreeing that they worked with the DHB during the application process (33%), compared to 85% of PHO respondents. This suggests that the PHO acted as the connection between the DHB and the practice for the application process for VLCA funding.

The response to the question about the strength of relationships between the DHB and the practice and PHO was much more positive, with the majority of respondents agreeing that they had a strong relationship before the VLCA funding (84%). Again, PHO respondents were more positive about their DHB relationship, with all of them agreeing, compared to three-quarters of practices respondents (75%).

**Figure 21: Relationship with the DHB during the application [Practice and PHO respondents involved in the application]**



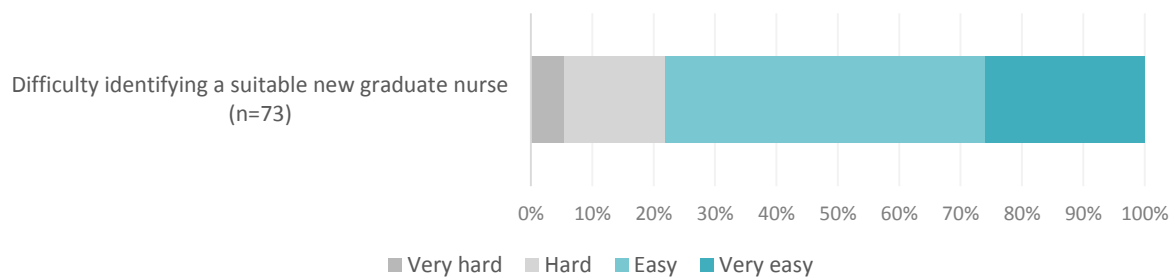
### 6.2.1 Nurse selection and identification

Similar to the section on the VLCA application process, every survey respondent except for the NGNs was asked if they were involved in the selection process for the NGN. Of these respondents, just over half (56%) were involved in the selection process to some degree.

The distribution of respondents involved in the selection process was very similar across all of the roles, with a relatively equal proportion of Practice, PHO and DHB respondents involved in the process (approximately half for each role).

Survey respondents were broadly positive about the ease of finding a NGN, with over three-quarters finding it easy to find a suitable graduate (78%). There was however a consistent minority of respondents who disagreed across Practice, PHO and DHB staff (Figure 22).

**Figure 22: Difficulty identifying NGN [all respondents involved in the selection process]**



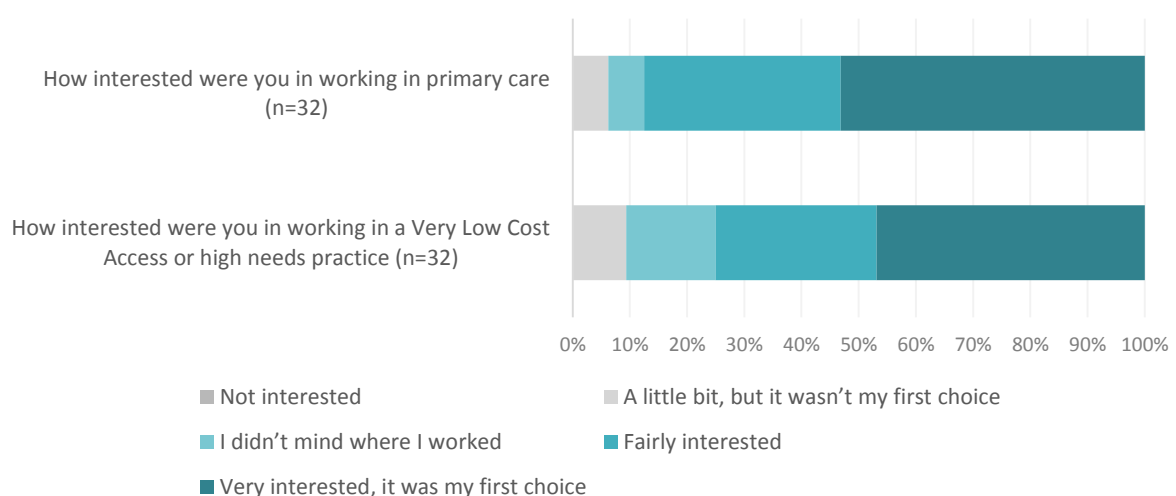
While overall the respondents found it easy to find a NGN to employ, there were some comments in the open-ended question that indicated that the range of NGNs available was limited:

*“It was difficult because we only had the choice of the left over talent pool. The timing was very close to Christmas and very tight.”*

#### 6.2.2 New Graduate Nurse motivation for taking the role

When the NGN respondents were asked about their motivations for taking the role in the VLCA practices, half said they were ‘very interested’ in working in Primary Care (53%), and just under half indicated they were ‘very interested’ in working in a VLCA or High Needs practice (Figure 23). A substantial majority of NGNs were either ‘very interested’ or ‘fairly interested’ in working in Primary Care (88%) or a VLCA practice (75%).

**Figure 23: NGN's motivations for taking the role [NGN]**

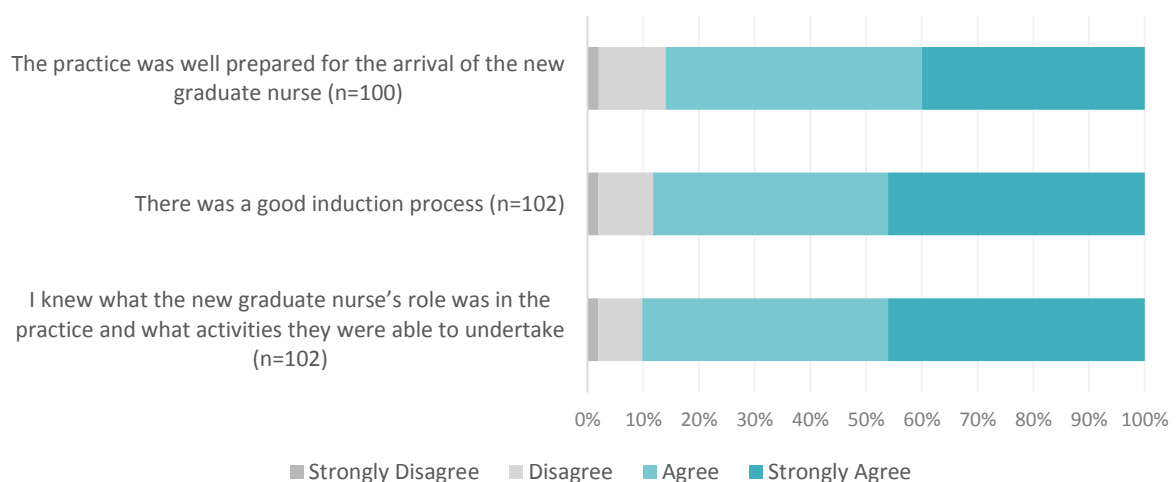


### 6.3 PRACTICE READINESS

Almost all of the Practice respondents thought the practice was prepared for the arrival of the NGN (86% agreeing or strongly agreeing), thought there was a good induction process (88%), and understood what the NGNs role in the practice was (90%; Figure 24).

However, a substantial minority of Practice Nurses and NGNs did not think that their practice was well prepared for the arrival of the NGN (29% and 33% respectively). Similarly, a minority of Practice Nurses, NGNs, and other practice staff disagreed that the induction process was good (20%, 19% and 22% respectively), and disagreed that they understood the role of the NGN in the practice (22%, 16% and 11% respectively).

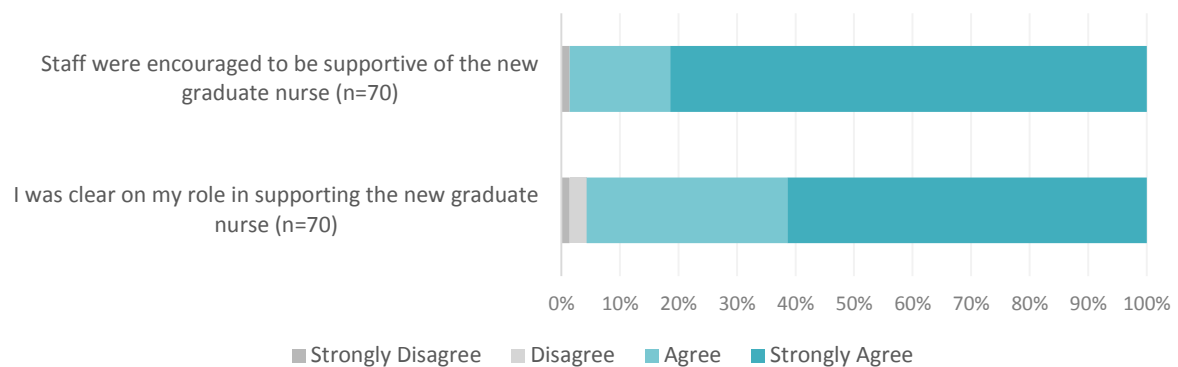
**Figure 24: Practice readiness [Practice respondents]**



All but one of the respondents from the VLCA Practices agreed that they were encouraged to support the NGN (99%), with only one Practice Nurse disagreeing (Figure 25).

Similarly, almost all respondents were clear about their role in supporting the NGN (96%), however a small minority disagreed, with one Practice Nurse, one Practice Manager and other practice staff disagreeing.

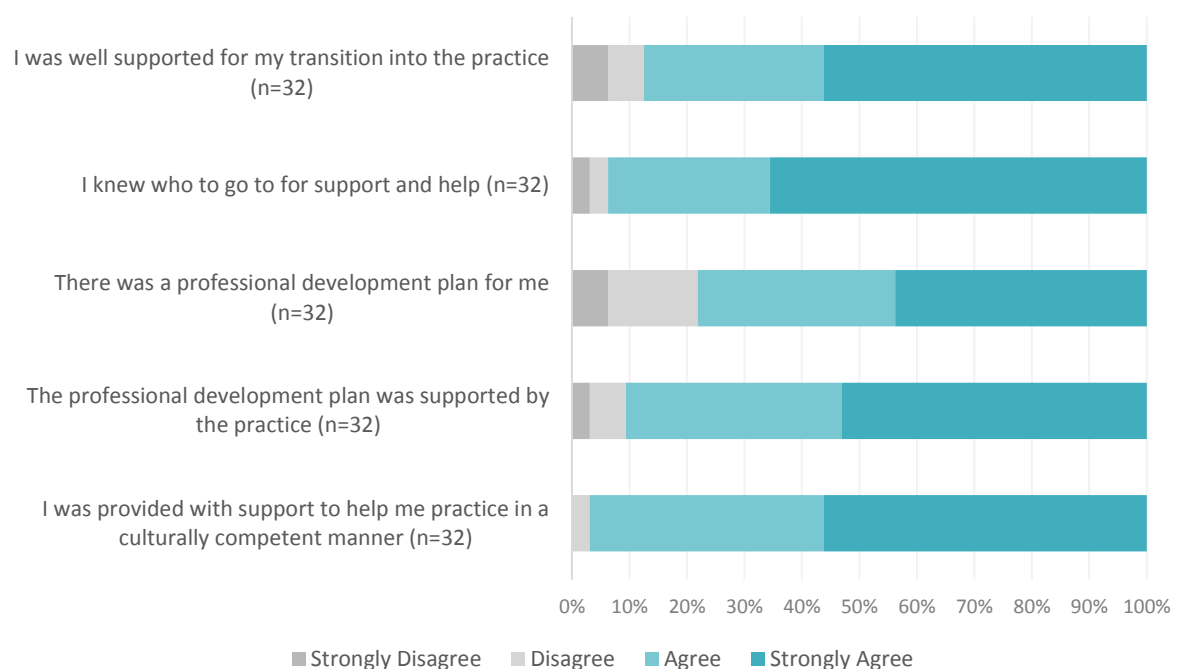
**Figure 25: Practice support during implementation [Practice staff excluding NGN]**



A substantial majority of NGNs felt supported by their practice during the implementation of their role with 88% agreeing they were supported during their transition into practice and 94% agreeing they knew who to go to for help and support (Figure 26). Over three-quarters of NGNs had a professional development plan (78%) and the majority of respondents indicated that the plan was supported by the practice (91%).

All but one NGN felt they were supported to practice in a culturally competent manner (97%). Māori NGNs were more likely to strongly agree that they were supported in a culturally competent manner than non- Māori NGNs, but the overall level of agreement was similar.

**Figure 26: Practice support during implementation [NGN]**

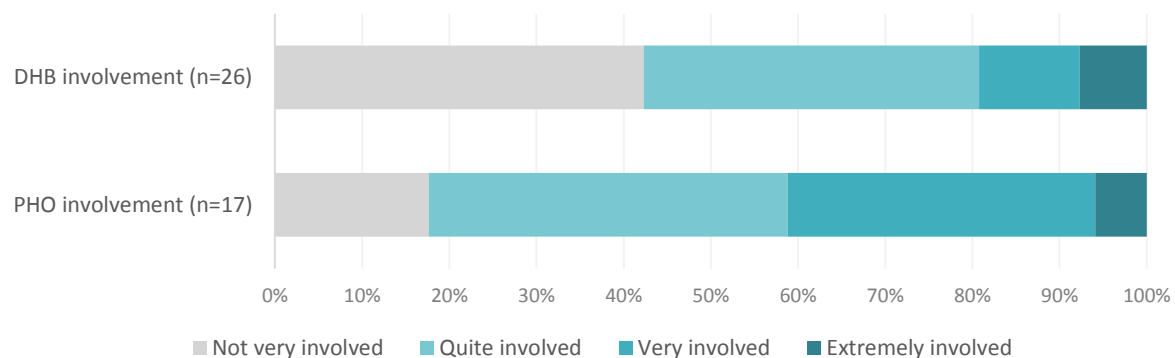


### 6.3.1 District Health Board and Primary Health Organisations' involvement

When asked about their involvement in the implementation of the initiative, the PHO Staff were more likely to say that they were involved in the implementation of the initiative, than the DHB staff and the NETP Coordinator.

The majority of PHO respondents were at least 'quite involved' in the implementation of the NGN role (82%) and two-fifths were at least 'very involved' (41%; Figure 27). This was compared to only three-fifths of DHB respondents indicating they were 'quite involved' (58%) and only a fifth indicating they were 'very involved' in the implementation.

**Figure 27: DHB and PHO involvement in implementation [DHB and PHO respondents]**



DHB involvement included the provision of the NETP programme including study days, coordinating the assessment component, practice visits and providing preceptor support. They also played a role in assisting with applications and NGN recruitment as well as monitoring progress and ensuring reporting requirements would be met. The range of activities they have been involved in is evident by the following comment:

*"The DHB (myself) worked closely with each PHO identify and encourage suitable practices to take a new grad. My team has regularly contact for the NETP programme with the practice team and the NGN. My team runs the study days and supports the new graduate in their clinical practice and supports the preceptor in the practice. My team is involved in supporting and the assessments for the new graduate year including their post graduate paper."*

Some of the PHOs also had a role in assisting with applications and recruitment. This included identifying which practices might be suitable for the initiative. The PHO also played a role in

development of the NGN with comments that indicated they made regular contact, assisted in the orientation, and provide ongoing education and peer support.

When asked about the key challenges to support the implementation of the initiative, the DHB staff identified:

- Difficulties engaging practice.
- Distance to reach the practice.
- Lack of existing relationship with the practice.
- Lack of time for the initiative.
- Lack of understanding of NETP programme and the NGN role at some practices.

Some of these challenges are illustrated by the following comments:

*“Primary care lack of understanding of the intent of the NETP programme and their responsibilities to the programme and the new graduate.”*

*“The organisation did not really engage with the NETP co-ordinator.... Organisation wanting to use new graduate RN as receptionist role when receptionist had extended sick leave. This was reversed after NETP co-ordinator met with the Practice Manager.”*

PHOs were more likely to suggest that there had been no real challenges than the DHBs. Some did mention distance, lack of time, and difficulties engaging the practice around the initiative.

*“The practice does not necessarily view the PHO as needing to be involved in any way.... It would be great for PHOs to hear first-hand from new grads what they view the challenges of being within the practice they are working in.”*

The DHBs and the PHOs identified the following as key enablers to implementation:

- Having a well-established NETP programme.
- Nursing education and development staff.
- NETP coordinator visits.

*“The NETP program is a well-established program that provides support and education to the graduate nurses enabling them to become competent nurses with the possibility of a role with the DHB once the NETP is completed.”*

Other enablers that were only mentioned once and are more specific to an individual context included having a nurse educator that was recognised as an experienced primary health care nurse, leadership, and PHOs and practices that were already working together.

When asked about what other supports they could provide the DHBs and PHOs suggested they could have a role in:

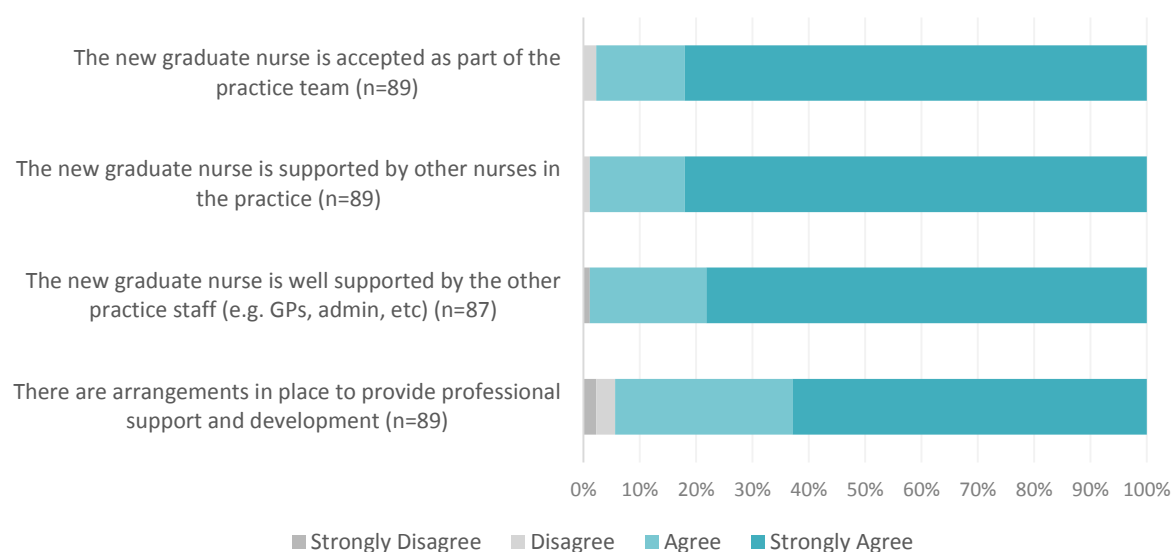
- Identifying what is needed to ensure the sustainability of the NGN's employment
- Providing ongoing access to the nursing development team and education including the PDRP programme.
- Including a Long Term Conditions study day.

#### 6.4 INTEGRATION OF NEW GRADUATE NURSE

Overall, the NGNs were well integrated into the practices, being accepted as part of the team (98% agreeing or strongly agreeing; Figure 28), supported by other nurses (99%) and supported by other practice staff (99%). Only one Practice Owner disagreed that the NGN was part of the practice team and, of particular note, there was one NGN who disagreed with all three questions - indicating they felt poorly integrated into the practice.

The majority of respondents agreed that there were arrangements in place to provide professional development or support (94%), however a small minority of NGNs and Practice Nurses disagreed.

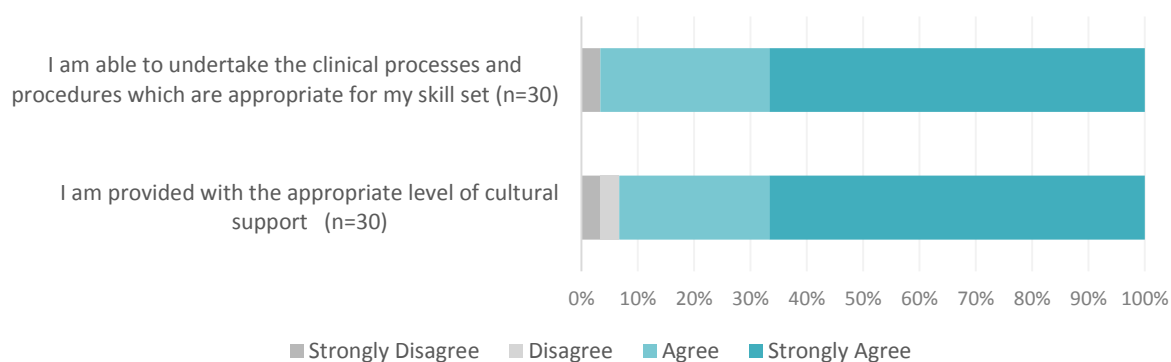
**Figure 28: Integration and support of NGN into the practice [Practice respondents]**



Almost all of the NGN respondents felt they were undertaking clinical processes which were appropriate for their skill set (97%) and were provided with the appropriate level of cultural support (93%; Figure 29). There were no major differences between Māori and non- Māori NGNs when asked if they were provided the appropriate level of cultural support, though Māori may have agreed slightly stronger.

Although two NGNs disagreed that they received the appropriate level of cultural support, one of them also disagreed that they were able to undertake the clinical processes and procedures appropriate to their skillset. This was the same NGN who disagreed with the integration questions above.

**Figure 29: Clinical and cultural appropriateness [NGN]**



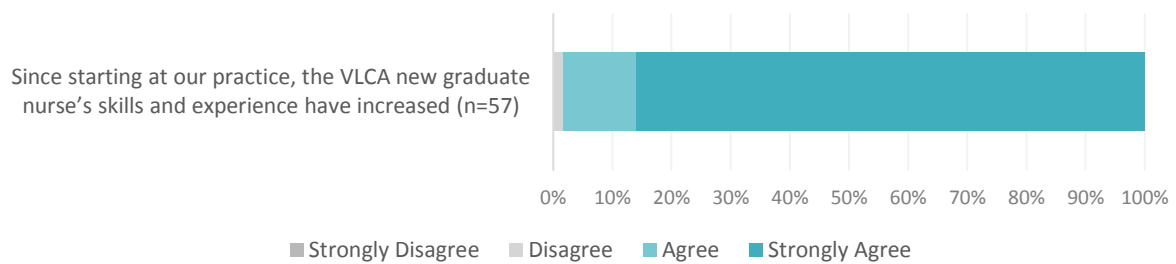
## 6.5 NEW GRADUATE NURSE DEVELOPMENT AND SUPPORT

### 6.5.1 Increases in ability to undertake clinical processes and practices

All but one of the Practice respondents agreed that since starting at the practice the NGN's skills and experience had increased (98%), with the substantial majority strongly agreeing (86%; Figure 30). Only one Practice Manager disagreed that the NGN's skills and experience had increased.



**Figure 30: Change in NGN skills and experience [Practice respondents excluding NGN]**

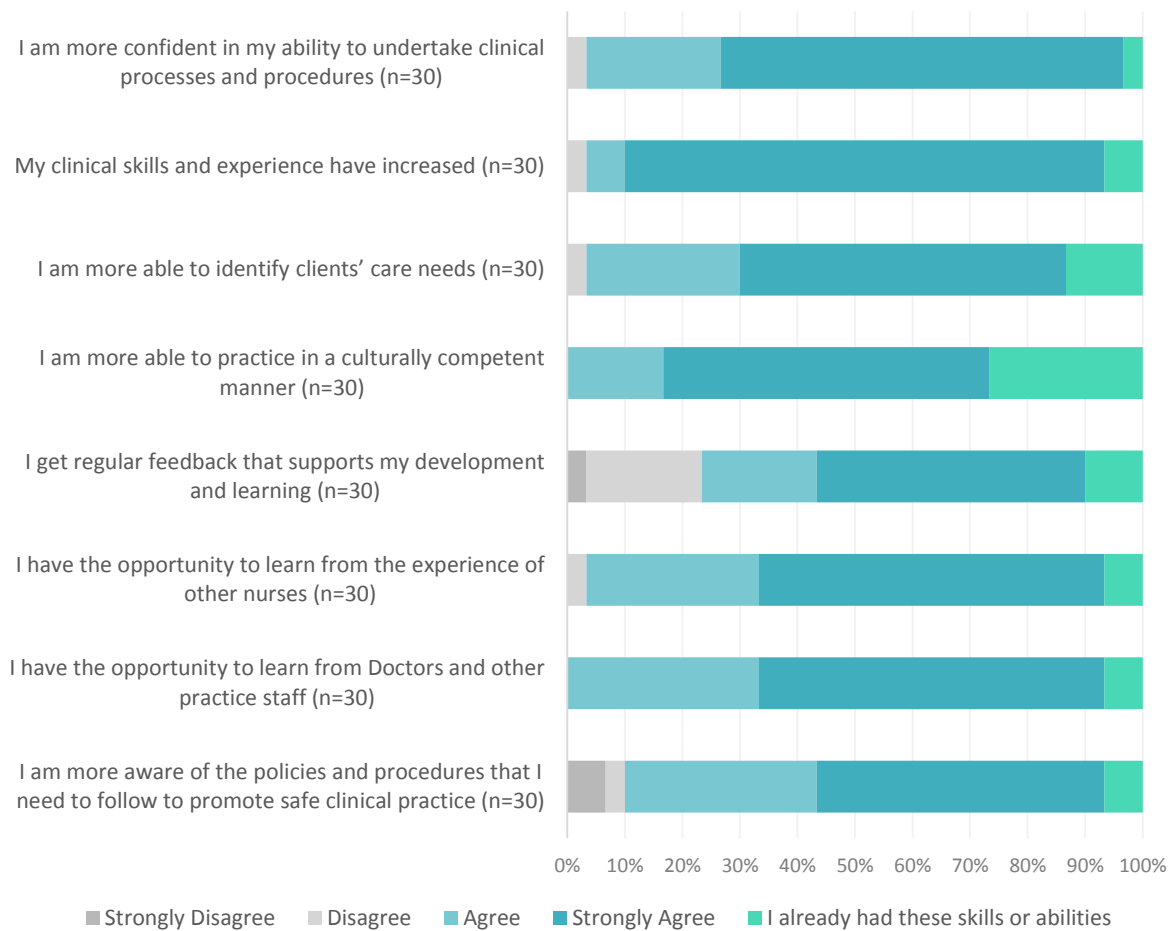


Overall, the NGNs reported an improvement in their skills and experience (Figure 31):

- 93% of NGNs agreed that their confidence in undertaking clinical procedures had improved, with 70% strongly agreeing
- 90% of NGNs agreed that their clinical skills and experience had increased, with 83% strongly agreeing
- 83% agreed that they are more able to identify client's needs
- None of the NGNs disagreed that they were more able to practice in a culturally competent manner, with 73% of NGNs agreeing and 27% indicating that they already had the skills and abilities to practice in a culturally competent manner. While the level of agreement between Māori and non-Māori NGNs was similar, Māori NGNs were more likely to indicate that they were already able to practice in a culturally competent manner.
- While the majority of NGNs agreed that they get regular feedback that supports their learning and development (67%), almost a quarter (23%) disagreed.
- 90% of NGNs had the opportunity to learn from other nurses
- All of the NGNs had the opportunity to learn from Doctors or other practice staff (excluding the 7% who felt they had already experienced working with practice staff)
- 83% of NGNs felt they were more aware of the policies and procedures required for safe clinical practice.

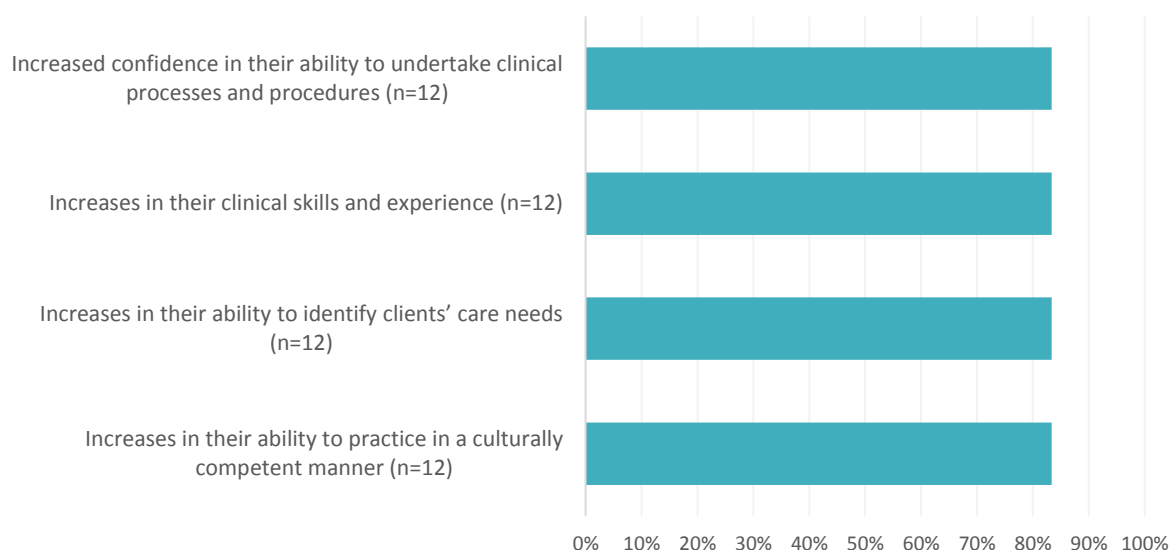
One NGN in particular felt that their skills and experience hadn't improved in the initiative, consistently disagreeing to many of the questions.

**Figure 31: Change in skills and experience [NGN]**



There was no variation across the NETP coordinators when asked about the change in NGN's skills and experience with 83% (10 out of 12) NETP selecting yes for increase in NGN's confidence, increase in clinical skills and experience, increase in ability to identify client's needs and increase in the NGN's ability to practice in a culturally competent manner (Figure 32).

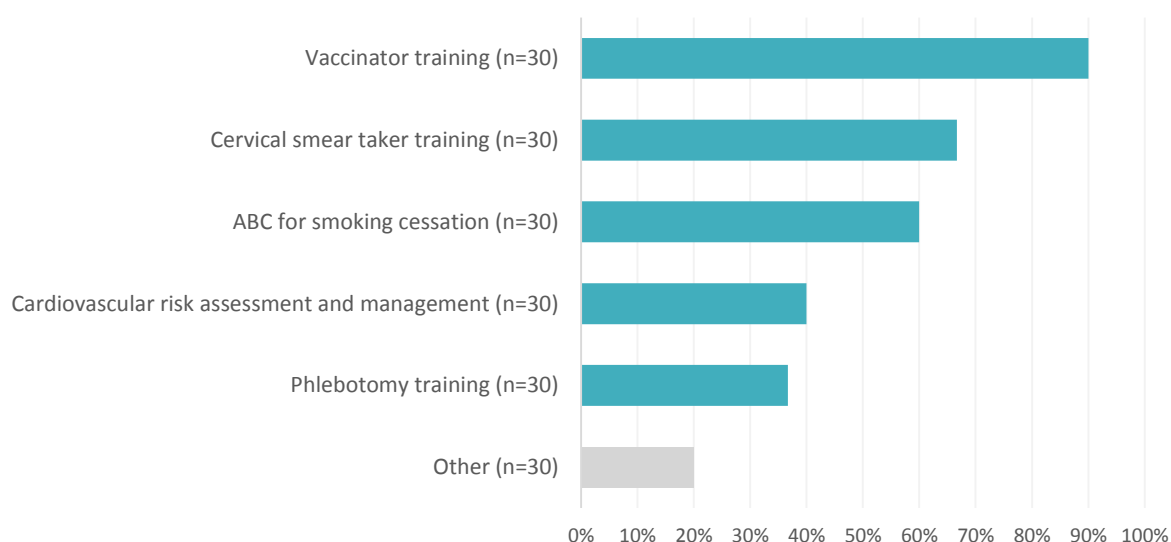
**Figure 32: Change in skills and experience [NETP]**



All of the NGNs indicated that they had undertaken some form of formal training or gained a certification during the VLCA initiative. Almost all of the NGNs had completed Vaccinator training (90%), two-thirds had completed Cervical Smear taker training (67%) and three-fifths had completed ABC for smoking cessation (60%; Figure 33).

The most common 'Other' activities were Spirometry and Sexual Health training.

**Figure 33: Formal training/certifications gained [NGN]**



The NGNs were also asked to identify any other training that they would like to receive. The most common was diabetes training with five NGNs stating this as something they would like to receive. Other training included: phlebotomy, chronic illnesses, mental health, sexual health, triage, Med Tech, family planning, wound care and palliative care.

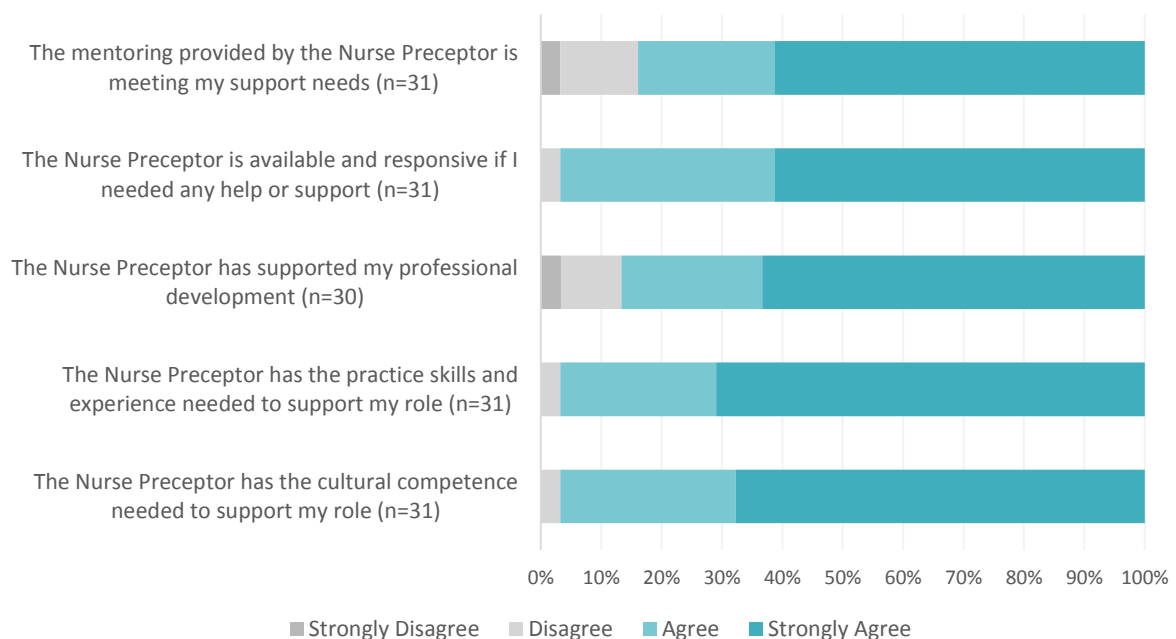
## 6.6 QUALITY AND LEVEL OF SUPPORT AVAILABLE FOR THE NEW GRADUATE NURSES

### 6.6.1 Nurse preceptor support

Overall, the NGNs responded very positively to the questions on the support provided by the nurse preceptor. Specifically, the NGNs suggested that the Nurse Preceptor:

- Is providing mentoring that is meeting their support needs (with 84% at least agreeing and 61% strongly agreeing; Figure 34).
- Is available and responsive when the NGN needs help (with 97% at least agreeing and 61% strongly agreeing).
- Has supported their professional development (with 87% at least agreeing and 63% strongly agreeing).
- Has the practice skills and experienced required to support their role (with 97% at least agreeing and 71% strongly agreeing).
- Has the cultural competence needed to support their role (with 97% at least agreeing and 68% strongly agreeing).

**Figure 34: Nurse Preceptor support [NGN]**



For three-quarters of the NGNs, the nurse preceptor was the first person they went to for support (74%). Those in the remaining 26% often sought support from others in the practice or whoever was available at the time. This reflects the broader support that was provided for the NGNs at the practice:

*“Everyone works as a team. If there are questions I feel only my preceptor can answer than of course I will go to her. But quite often other team members are more than competent to answer any queries or clarification I may need. Which they do and I will always follow up with my preceptor anyway.”*

For a few NGNs however, this type of support was less accessible:

*“My preceptor worked in a different part of the practice and this made it difficult to have her support. However she did the best that she could for me. Whist in the clinic I was left in some very unsafe situations having no official guidance.”*

*“My allocated nurse preceptor has many other roles and I sometimes feel she is too busy to answer my worries or queries about what is expected of me. I feel supported by other nurses at the practice however.”*

The survey asked nurse preceptors to identify their training and previous experience. The responses indicated that:

- All of the Nurse Preceptors had undertaken preceptor training.
- Eleven of the sixteen preceptors held a post-graduate qualification (69%).
- Only two of the nurse preceptors **had not** been in this role before (12%).

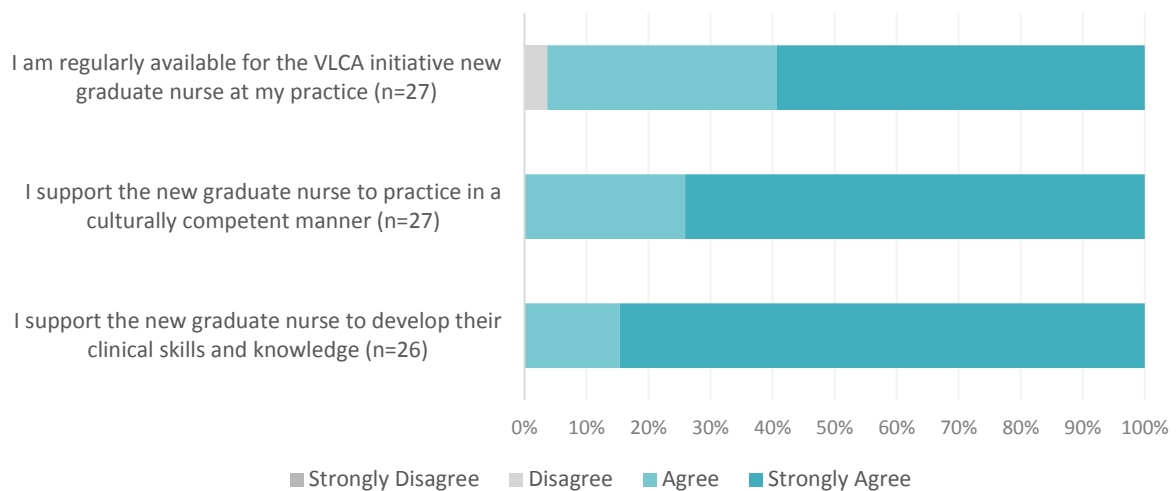
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#### 6.6.2 Nurse preceptor role

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Almost all Nurse Preceptors suggested that they were regularly available to support the NGNs (96% or 26 respondents agreeing or strongly agreeing; Figure 35), and all of them indicated that they supported NGNs to develop clinical skills and knowledge (100% agreeing or strongly agreeing). The response from Nurse Preceptors was particularly strong when asked about supporting NGNs to practice in a culturally appropriate manner, with all Preceptors agreeing and most strongly agreeing (85% or 22 respondents).

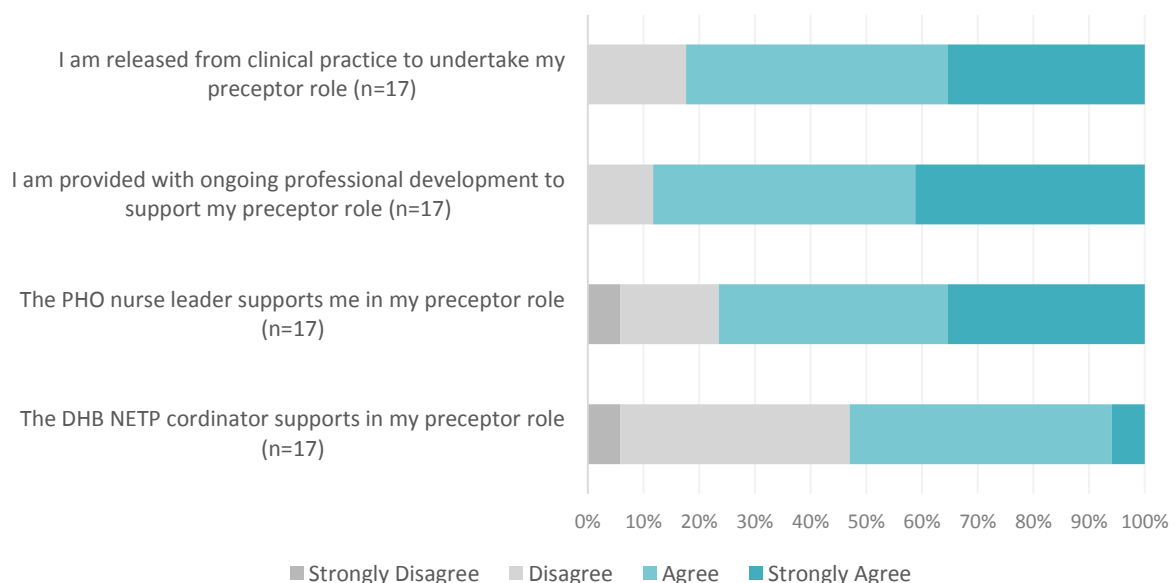
**Figure 35: Support provided by Nurses and Preceptor [Nurse Preceptor and Practice Nurses]**



Most of the Nurse Preceptors indicated that they were provided with ongoing professional development to support their preceptor role (88% or 15 respondents agreeing or strongly agreeing). This included being released from clinical practice to undertake their clinical role (82% or 14 respondents; Figure 36).

Three-quarters of Nurse Preceptors indicated that the PHO nurse leader supported them in their preceptor role (76% or 13 respondents), while only half agreed that the NETP coordinator supported them (53% or 9 respondents). This suggests that support for the Nurse Preceptor was not always available from the DHB or the PHO.

**Figure 36: Support for the Nurse Preceptor [Nurse Preceptor]**



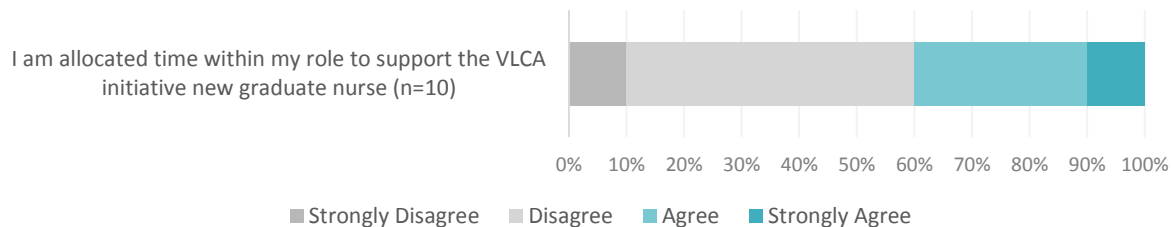
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### 6.6.3 Practice Nurse role

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Less than half of the Practice Nurses felt that they were allocated sufficient time within their role to support the NGNs (40% or 4 respondents; Figure 37).

**Figure 37: Support for the Practice Nurses [Practice Nurse]**



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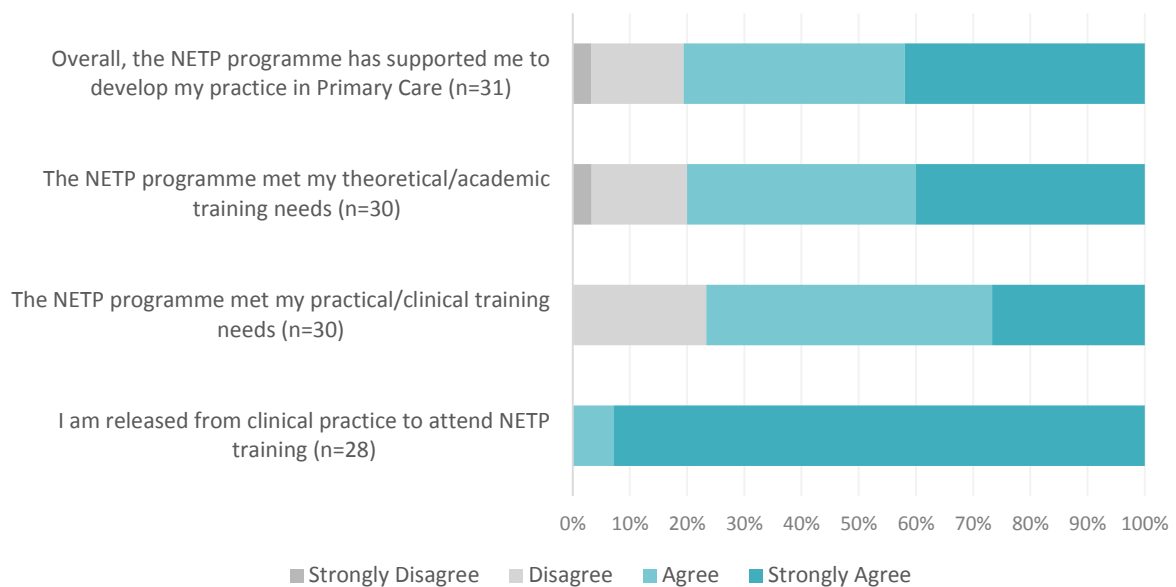
### 6.6.4 NETP Support for the new graduate nurses

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The majority of the NGN suggested that the NETP programme:

- Supported their professional development in primary care (81% agreeing or strongly agreeing; Figure 38).
- Met their theoretical and academic training needs (80%).
- Met their practical and clinical training needs (77%).
- All of the NGNs suggested that they were released by their practice to attend their NETP training (100%).

**Figure 38: Support provided by the NETP [NGN]**



The open ended questions in the survey suggested that the NGNs particularly valued:

- Diabetes and wound care day.
- ECG training day.
- Funding to do immunisation and smear taking courses.
- The clinical focussed assessments.
- Access to the University databases.

It is important to note that in comparison to the nurse preceptors, the NGNs were slightly less likely to suggest that the NETP programme meet their training and support needs. Specifically, a minority of the NGNs suggested that:

- The NETP programme did not support their professional development in primary care.
- The NETP programme did not meet their theoretical or academic training needs.
- The NETP programme did not meet their practical or clinical training needs.

This notion is reflected in the following comment:

*“Too much focus on inpatient and the work environment and nature of the inpatient setting. That Primary care has had little focus. ... Sometimes feels like a day at NETP training is irrelevant and I’d rather be at work learning more and increasing my knowledge there.”*



Some also struggled to manage the study with their workloads:

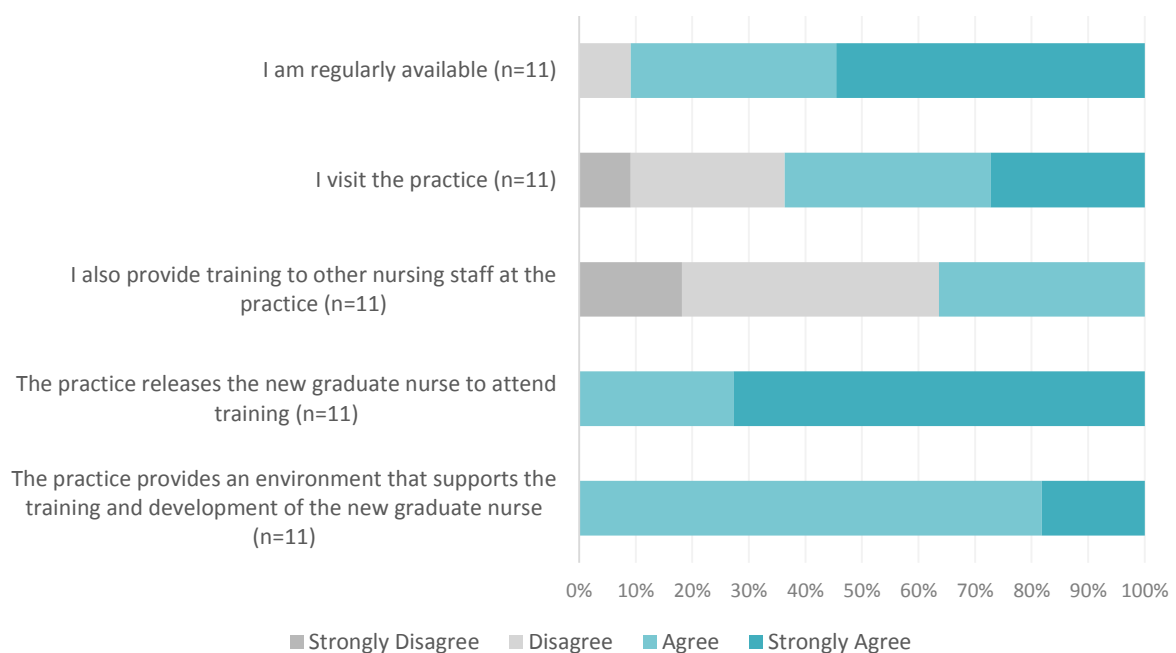
*“There is just too much to do on top of working full time; I feel that it is too much and leaves little time to study things that are relevant to my area of practice.”*

Nearly three-quarters of the NGNs also suggested that the NETP coordinators came out to their practice (74%), and two-thirds involved other practice staff in the training and support (64%; Figure 39).

In contrast, while two-thirds of NETP respondents indicated they visited the VLCA practice (64%), only a third also provided training to other nursing staff (36%).

Almost all NETP coordinators were regularly available to support the NGN (91%) and all coordinators indicated that the practice releases the NGN for training and provides an environment that supports the training and development of the New Graduate.

**Figure 39: Support provided by the NETP [NETP]**



## 6.7 IMPACTS

### 6.7.1 Impacts on the practice

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Survey respondents were asked about the impact of the NGN on the VLCA practices. At this stage of implementation, most of the respondents indicated that the NGN had:

- Increased the support available to other clinicians (86%),
- Introduced new skills or processes (80%)
- Increased the availability of capable staff to support succession planning (86%)
- Increased practice performance on targets (86%).

Generally Practice staff were slightly less likely to agree that the NGN had an impact on these measures, while PHO and DHB staff were slightly more likely to agree.

When comparing Māori and non- Māori VLCA providers<sup>6</sup>, respondents from Māori providers were less likely to agree that the NGN had introduced new skills or process (68% agreement for Māori vs 80% agreement for non-Māori practices).

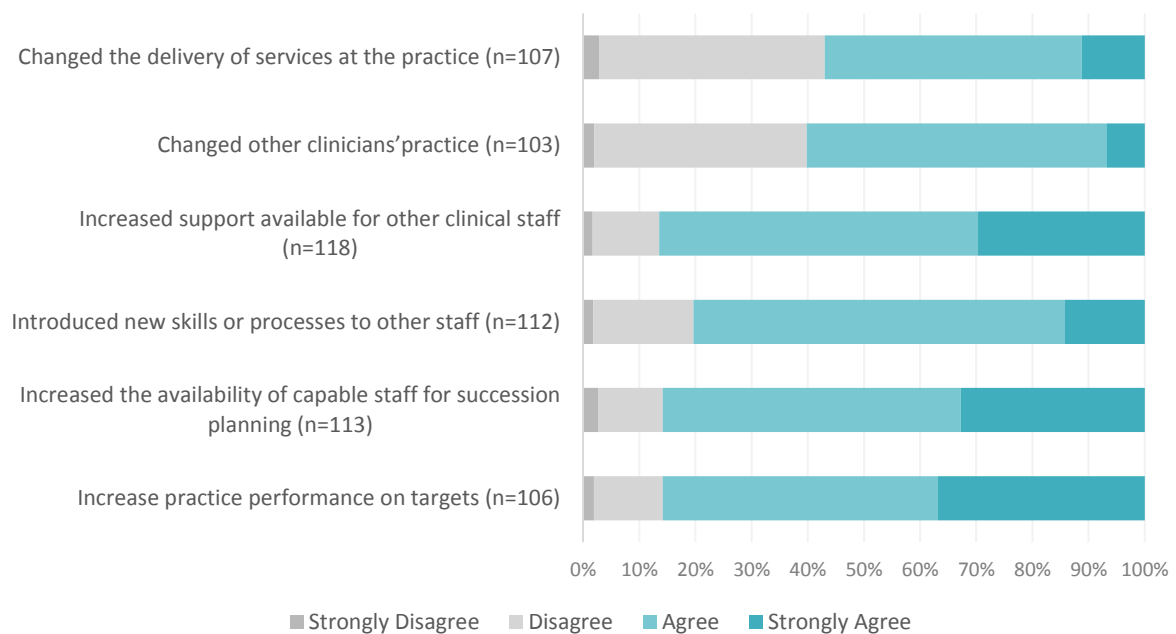
When asked about the impact of the NGN role on the model of care and business model at the practices, the findings indicated that:

- Three-fifths of respondents indicated that the NGN had changed the delivery of services at the practice (57%; Figure 40). Business owners and Managers were slightly less likely to agree that this had changed, while PHO and DHB respondents were slightly more likely to agree.
- Three-fifths of respondents suggested that the NGN had changed the way other clinician's practice (60%). DHB and PHO respondents were more likely to agree compared to respondents from VLCA practices (including NGNs).

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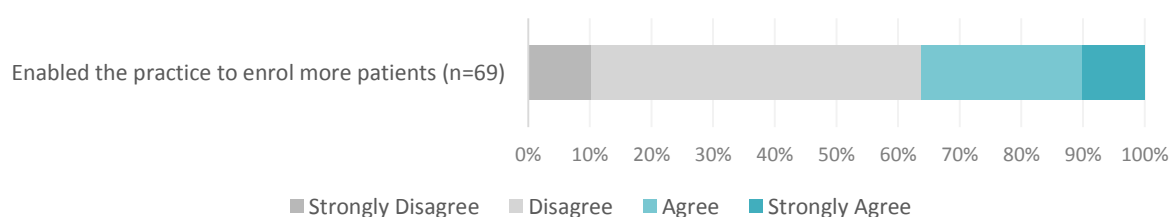
<sup>6</sup> Māori provider is defined here as a Māori provider with general practice services and non-Māori provider similarly includes those who provide general practice services.

**Figure 40: Impact of the NGN on the practice [all respondents]**



All of the survey respondents, except for the NGN, were also asked if the NGN had an impact on patient enrolments. Only a third of respondents felt that the NGN had increased patient enrolments (36%), which was fairly consistent across respondent roles. Trends in the survey data suggest that respondents from Māori providers were more likely to agree that the NGN had enabled the practice to enrol more patients (40% agreement for Māori vs 28% agreement for non-Māori providers).

**Figure 41: Impact of NGN on patient enrolments [all respondents except NGN]**



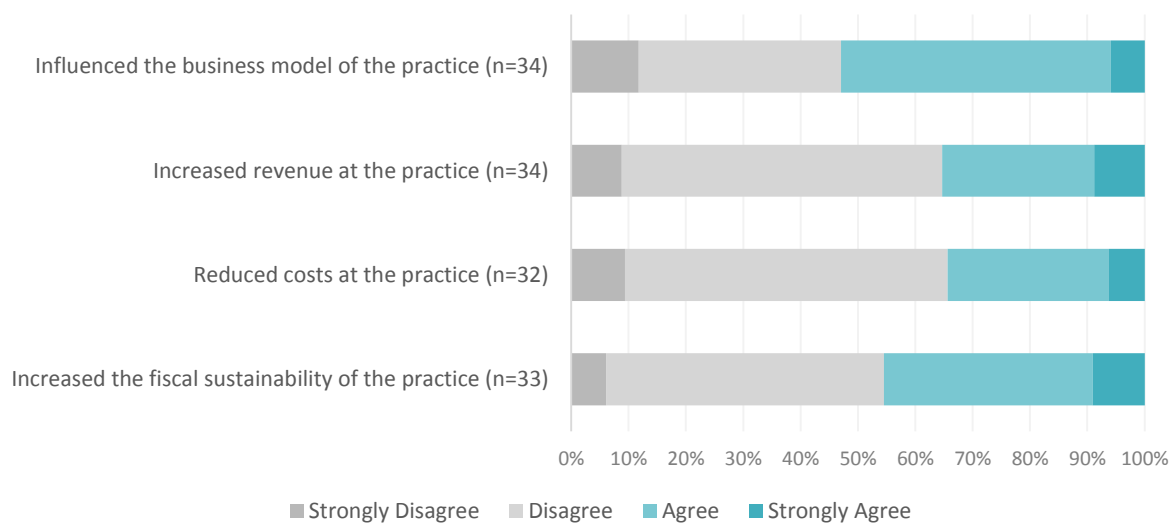
### 6.7.2 Impacts on the practice sustainability

Business owners and Manager were asked a number of questions about the impact of the NGN on financial and practice sustainability. Overall these respondents were less positive about the impact of the NGN:

- Half of Business owners and Managers suggested that the NGN had influenced the business model of the practice (53%)
- A third of respondents indicated that the NGN had increased revenue at the practice (35%) and reduced the costs at the practice (34%).
- Just under half felt that the NGN increased the fiscal sustainability of the VLCA practice (45%)

Overall, the responses to the questions around practice sustainability were very similar between Business owners and Practice Managers.

**Figure 42: Impact of the NGN on practice sustainability [Business owners and Managers]**



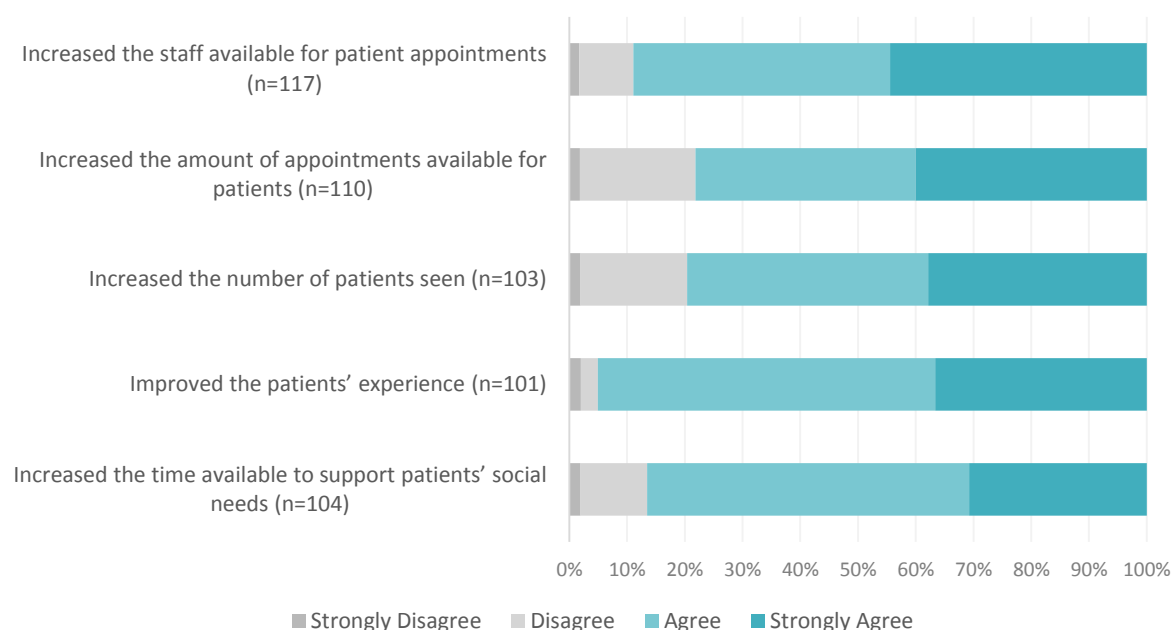
### 6.7.3 Impacts on patient experience

In terms of patient experience, survey respondents suggested that the NGN had:

- Increased the number of staff available for appointments at the practices (89% agreeing or strongly agreeing; Figure 43).
- Increased the number of appointments available to patients (78%).
- Increased the number of patients seen at the practice (80%).
- Improved patients' experience (95%).
- Increased the time available to support patients' social needs (87%).

While there were slight differences in the levels of agreement about the impact of the NGN on patient experience between the respondent roles, no specific role agreed or disagreed consistently more than others. Respondents from Māori VLCA providers were less likely to agree that the NGN initiative had increased connections between the Practice and the PHO (41% agreeing for Māori vs 53% for non-Māori practices).

**Figure 43: Impact of the NGN on patient experience [all respondents]**



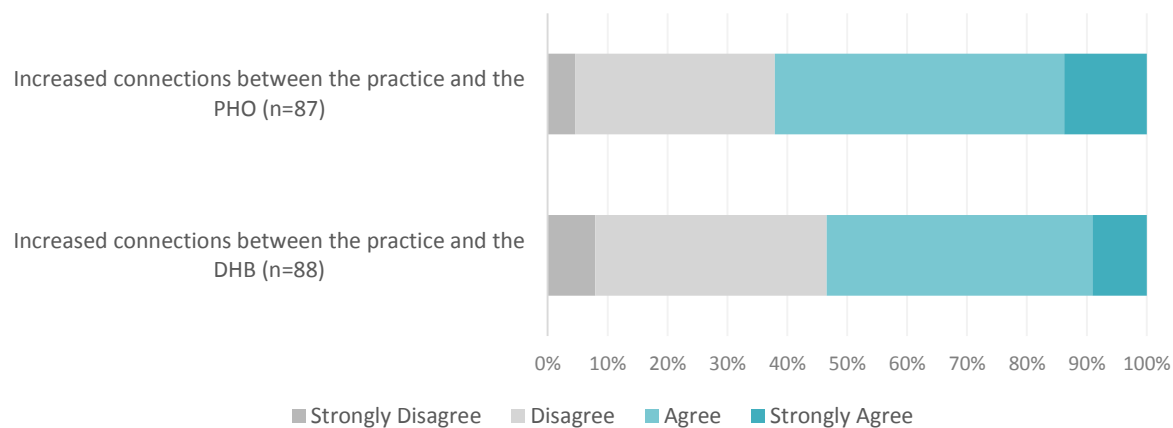
#### 6.7.4 Impacts on the relationship between the practices, Primary Healthcare Organisations and District Health Boards

The survey also explored the impact of the initiative and its implementation of the relationships between the Practice, PHOs and DHBs. Almost two-thirds of respondents felt that the NGN initiative had increased the connections between the practice and PHO (62%) and roughly half felt that the initiative had increased connections between the practice and the DHB (53%).

PHO and DHB respondents were substantially more likely to agree that the initiative had increased connections between the practice and PHO than respondents from the VLCA practices (80-100% agreement for PHO and DHBs vs 40-60% for Practice staff).

DHB staff were also more likely to suggest that the initiative had increased connections between the DHB and the practices than PHO and practice staff, though this difference wasn't as pronounced.

**Figure 44: Impact of the NGN on the relationships between practices, PHOs, and DHBs [all respondents except NGN]**



## 6.8 BENEFITS

The survey invited stakeholders to identify the key benefits of the initiative for them and for their practice or organisation.

### 6.8.1 Benefits for practice nurses

When asked to identify the individual benefits of the initiative, the practice nurses' (Nurse Preceptor and Practice Nurse) identified a number of interesting benefits. The most commonly cited benefits were:

- Being able to bring more local NGNs into primary care:
  - *"Employing a skilled, local Māori NGN."*
  - *"Increase Māori nurses in GP practice."*
  - *"Recruiting a potential Pacific nurse to keep long term."*
  - *"Bringing new 'blood' into primary care before they get snaffled up by the DHB who pay more."*
- Having an extra pair of hands on deck to support the workload and practice development:
  - *"More nurses for patients to see."*
  - *"It has allowed more time for the Practice Nurses to go off and increase their training by attending workshops held by DHB and PHO. When I first started here all the Nurses were inundated with the high demands of patients".*

- Having the NGN support their own practice or career development i.e. sharing of new skills and knowledge:
  - *“Having the opportunity to Precept the New Grad although it was not my role. I saw her on occasion needing support so took the opportunity to awhi her as Practice Nurses should. It helped me increase my Leadership skills.”*
- Having another nurse to work with was also valued:
  - *“Being the only nurse in the practice; it has been good to have her to work with.”*

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#### 6.8.2 Benefits for practice managers and other practice staff

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Practice managers and other practice staff also identified a range of individual benefits of having the NGN through the VLCA initiative. Key benefits included:

- Having a new nurse at the practice and the value this can bring:
  - *“Managing staff resources was a little easier due to additional nurse.”*
  - *“Increased nurse cover - increased availability to patients.”*
- Being able to provide support to the NGN:
  - *“The co-operative efforts staff have made to integrate her into the practice and the enthusiasm that this has engendered amongst all staff.”*
- Financial support for the practice:
  - *“Having access to fund a new staff member to join our team.”*
  - *“Increased the workforce that without the funding we would not have been able to do.”*
- Having a culturally appropriate and responsive NGN:
  - *“A nurse that is culturally appropriate.”*
  - *“Patients and other staff members very happy to have VLCA new grad 'on board'. Our new nurse relates very well to our Māori and Pacific island patients; plus patients from all walks of life.”*
- Seeing the benefits for patients:

- *“Watching a new nurse work with high needs patients and ensure they get the screening and care they should.”*

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### 6.8.3 Benefits for business owners

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Business owners identified the following benefits to them individually:

- Having another nurse to support workload and patient care:
  - *“More nurse time available for appointments & follow up.”*
  - *“Taken a lot of the pressure off staff.”*
  - *“Existing nursing staff less stressed.”*
- More resources and support for succession planning:
  - *“Ensuring more resources and supports are in place to assist with practices serving a community that has so many challenges and complexities to deal with.”*
  - *“Succession.”*
- Increasing performance on targets:
  - *“Improved performance against PHO targets.”*
- Supporting practice of existing staff and supporting leadership development at the practice:
  - *“Bright and young and new ideas.”*
  - *“Developing leadership potential in the workforce.”*
- Supporting the development of a new graduate:
  - *“Watching someone develop in to a confident RN.”*
  - *“The co-operative efforts staff have made to integrate her into the practice and the enthusiasm that this has engendered amongst all staff.”*

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### 6.8.4 Benefits for the Primary Health Organisations and District Health Boards

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PHO and DHB staff identified a more unique set of benefits of the initiative to them including:

- Developing the future workforce and support for VLCA practices:
  - *“Building increased capability and capacity in Primary Care nursing workforce to sustain provision of care for the DHB population.”*
  - *“High Needs practices acknowledged with resource.”*



- Promotion of the NETP programme in primary care and more comprehensive views in the programme:
  - *“More PHC nurses on the NETP programme.”*
  - *“Having primary health as well as secondary care graduates on the programme means that on study days the graduates are able to get a far more comprehensive view of a client and the nursing care required.”*
- Opportunity to engage with different providers and increase connections:
  - *“An opportunity to engage with an Iwi provider.”*
  - *“It has increased my positive working relationship with the PHO by support these practices.”*
  - *“Getting to know the practice and practice staff better.”*
- Increasing presence of NGN in primary care and their value:
  - *“Funding to enable new graduate to primary care; particularly VLCA. Please note there are still barriers with other primary care providers for new graduates. These practices site funding and capability and competence as a barrier, they do not understand what new graduate brings.”*
  - *“Increased practices seeing the benefit and value of employing a new graduate within a supported programme for the first year who may take new graduates in the future.”*

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#### 6.8.5 Benefits for new graduate nurses

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NGNs also identified a number of benefits of being employed through the VLCA initiative. These included:

- Being well supported:
  - *“I have received an amazing amount of extra training and support as opposed to some of my colleagues in the DHB NETP programme.”*
- Gaining experience in a highly supportive workplace:
  - *“Being able to work in a practice setting that I love!!!”*
  - *“Getting some experience in a practice that has been so supportive.”*

- Gaining employment:
  - *“It has created a great job opportunity.”*
- Training and learning opportunities, including the NETP programme and the socialisation this brought:
  - *“Being offered a place on the NETP so I could join the programme and meet other new graduates.”*
  - *“Significant support from the practice to attend training days and workshops to further my skills and knowledge.”*
- Working in an area that reflected their personal interests and values:
  - *“I had the opportunity to be in my dream job.”*
  - *“Increasing the amount of time we have for each client; particularly those with high social needs.”*
  - *“To have to opportunity to work in a high health needs practice in primary health care.”*

## 6.9 FUTURE INTENTIONS

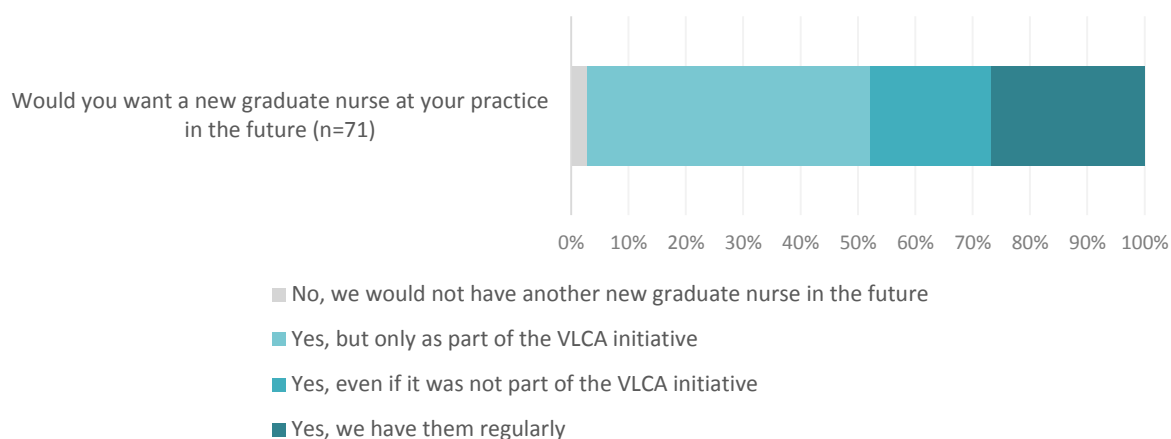
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### 6.9.1 Practice willingness to employ another new graduate nurse

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Almost all of the respondents from the VLCA practices were willing to have another NGN at their practice in the future (97%). However, half of the respondents indicated they would only have another NGN as part of the VLCA initiative (49%), while a fifth would have a NGN even if it wasn't part of the initiative (21%) and over a quarter stated they have NGNs regularly (27%).

**Figure 45: Intention to have a NGN in the future [Practice respondents]**



The practice who would not consider having a NGN in the future, suggested that the role reduced productivity by demanding time from an experienced nurse in the preceptor role:

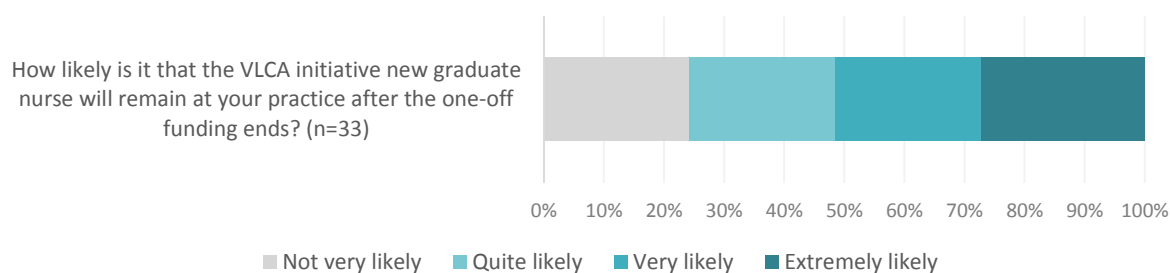
*“There is much downtime with taking on a new graduate.... In private practice this is a very costly exercise as it also reduces productivity of your preceptor.... Private practices only hire what they can afford and to have two salaries and your productive person reduced in time can be stressful as that person already has a large workload they need to maintain.”*

#### 6.9.2 Continued employment at the current practice

Half of Business Owners and Practice Managers indicated it was that it was ‘very likely’ (24%) or ‘extremely likely’ (27%) that the NGN would remain at their practice after the one-off VLCA funding ended. A quarter of respondents suggested it was not very likely that the NGN would stay at the practice after the funding ended (24%).

This split was similar between Business Owners and Practice Managers.

**Figure 46: Intention to keep NGN at practice [Business owners and Managers]**



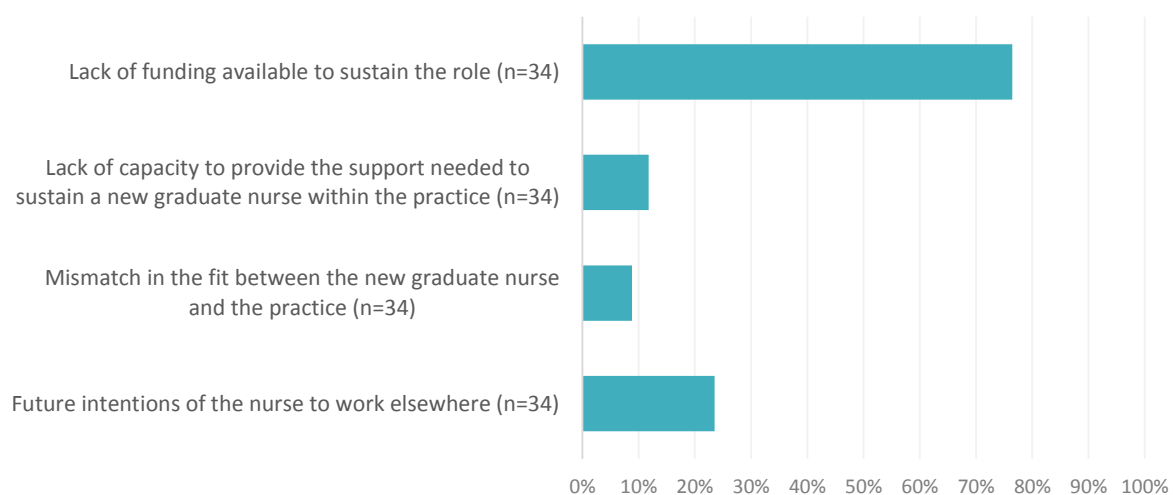
When asked what would be the key reason(s) for not continuing to employ the New Graduate Nurses, three-quarters of respondents indicated that there was a lack of funding available to sustain the role (76%).

*“The ONLY issue is money (& the nurse cannot generate her income from co-payments in a VLCA practice).”*

Lack of funding was slightly more important to Business owners than Managers, with 78% of Owners selecting the option, as opposed to 63% of Managers.

A quarter of respondents also suggested that the NGN intended to work elsewhere in the future (24%).

**Figure 47: Reasons for unsustainability of the NGN role [Practice Managers and Owners]**



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### 6.9.3 Business owners and practice managers approaches to sustaining the new graduate nurse role

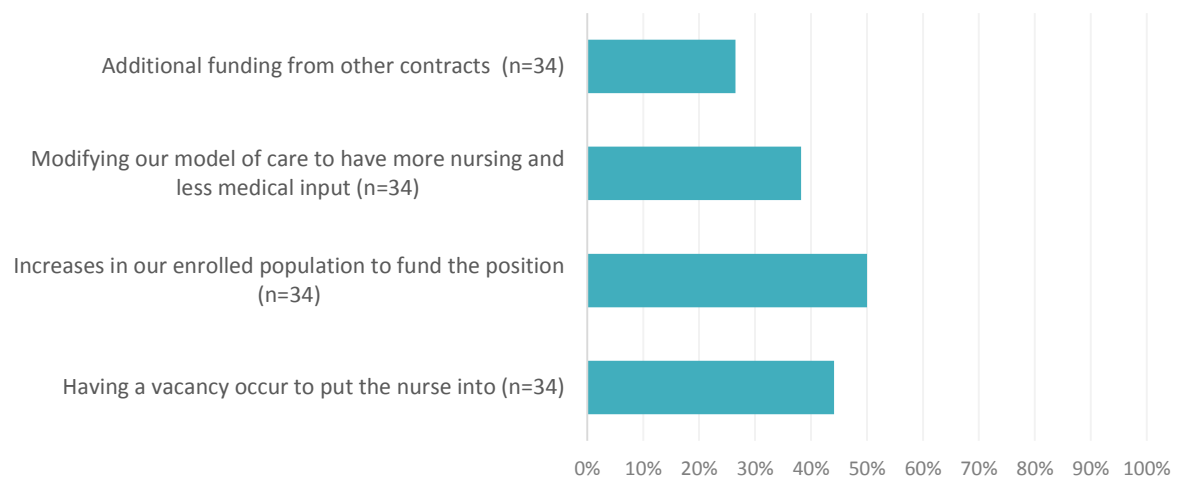
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Business Owners and Managers were then asked what steps they are taking to ensure the sustainability of the NGN after the 12 months of VLCA funding ended. Only two respondents didn't indicate any steps that they were undertaking.

Half of the respondents were looking at increasing their enrolled population to fund the position (50%), just under half were looking for a vacancy to place the NGN into (44%), two-fifths were considering modifying their model of care to have more nursing and less medical input (38%) and a quarter were investigating additional funding from other contracts (26%).

Business owners were much more likely to be considering funding from additional sources, while Managers were slightly more likely to be investigating changing their model of care or increasing their enrolled population.

**Figure 48: Factors enhancing NGN sustainability [Practice Managers and Business Owners]**



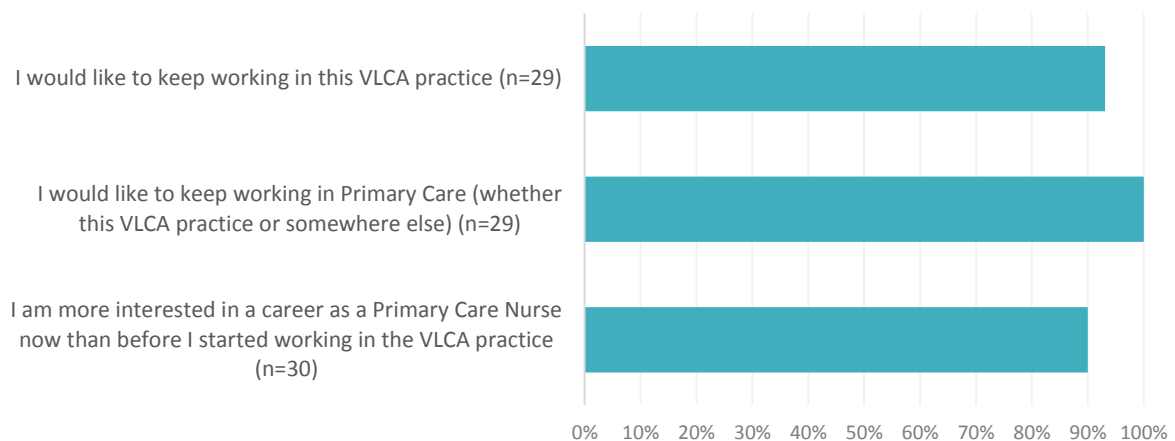
#### 6.9.4 New graduate nurse intentions to remain at their current practice

Almost all of the New Nurse Graduates would like to keep working at their VLCA practice (93%), and all of them would like to continue in Primary Care:

*“Overall; I find the work challenging; but hugely rewarding. After working in a nurse-led VLCA practice I would be hesitant to seek employment in a traditional medical centre.”*

Most of the NGNs were now more interested in a career as a Primary Care Nurse, than when before they started working in their VLCA practice (90%)

**Figure 49: Future intentions of the NGN [NGN]**



## 6.10 KEY CHALLENGES

Stakeholders identified the following key challenges to implementing the NGN role:

- Time that needed to be spent on training:
  - *“Finding one on one time in our busy work day.”*
  - *“Insufficient orientation time for the nurse; insufficient time allocated to other nurses to mentor/train her.”*
- Training focused on secondary care services:
  - *“Not having more Community focussed trainings for our New Grad; instead she was expected to go to DHB.”*
- Managing practice staff expectations of the NGN:
  - *“Getting some staff to recognise that this person is a NEW nurse and tempering their expectations accordingly.”*
- Process of applying for the initiative and identifying practice level support:
  - *“Completing the paperwork and getting somebody to come forward as a preceptor.”*
- Ensuring the sustainability of the NGN employment (most often mentioned by practice managers and/or business owners):
  - *“Practices are not in a financial position to retain this new graduate person beyond the end of the year.”*

- NGNs mentioned the challenges of adapting to a primary care setting and time management, including managing the many study obligations:
  - *“Finding time to work full time; do post grad studies and look after my family.”*

## 6.11 IDEAS FOR IMPROVEMENTS

Ideas for improvements suggested by the stakeholders included:

- Extending the timeframe of the initiative to go beyond twelve months, suggestions ranged between two and five years.
- An extended timeframe was considered to be important to realising the full benefits and potential of the initiative by some practice managers and business owners.
- Having greater focus on the primary care and community setting in the NETP programme.
- Partial ongoing funding from the government for the NGN position to support sustainability, especially for smaller practices.
- Improving the application process through increasing the time available to put together an application and aligning the timing more closely to the nurses graduations.
- Increasing NGN placements across primary care in general, not just VLCA practices.
- Outline the level of support required for an NGN, particularly for those practices who have not had an NGN before.
- Clearer contracts and reporting requirements from the outset of the initiative.

The business owners and practice managers were also asked to share their views on enhancing the sustainability of their practices. Increased funding was the most common response, although many also noted the value of initiatives similar to the VLCA Sustainability Initiative.

## 7. CONCLUSIONS

This report has provided a valuable insight into the views and experiences of key stakeholders involved in the implementation of the NGN employment scheme through the VLCA initiative.

The VLCA Sustainability Initiative has provided funding for 48 NGNs across 48 VLCA practices in New Zealand. The practices met the selection criteria of the initiative and had a high proportion of high needs patients. Many were also serving a higher proportion of Māori and Pacific in their enrolled population.

The findings indicate that the practices involved in the initiative intended to use the NGN role to support the sustainability of the workforce, practice sustainability and efficiency and to meet the needs of high needs patients. The applications forms also identified the role of the practice in providing support for the NGN and ideas for sustaining the role, with increasing enrolments or growing the business often being suggested. Some practices also suggested that adaptations to existing models of care could also sustain the role.

The application forms identified the intended role of the DHB and the PHO in supporting the practices involved in the VLCA initiative. The DHBs and PHOs were going to support the initiative in a number of ways. This often included providing clinical governance and leadership, a business advisor, quality improvement feedback, monitoring and reviewing of practice performance, and assisting with the practice model of care.

The survey suggests that the application process was challenging for some of the practices. Stakeholders suggested that the pre-Christmas timing and misalignment with the graduation time of nurses made the application process and nurse selection more challenging. Extending the timeframe for the application process itself was also often recommended.

Overall, the NGNs are well integrated into the VLCA practices and most of the practices were well prepared for the arrival of the NGNs. This is an important finding as the successful employment of the NGNs and their integration into primary care was a key evaluation indicator for the initiative.

Some of the practice staff suggested that they were less clear on their role in support the new graduate or the level of support that would be required. Practices being clearer on the role of staff in supporting the NGN and the level of support needed would be useful for some practices, particularly those who have not had a new graduate at their practice before.

The NGNs are receiving good support from nurse preceptors, the NETP coordinators and other practice staff. The survey suggests that this support could be further bolstered by adapting the NETP



programme to better reflect the primary care context within which the nurse are working. Most of the NGNs felt that they had an appropriate level of cultural support, although the next phase of the evaluation provides an opportunity to unpack the level and type of support that is happening for the NGNs.

Developing the skills and experience of NGNs in the primary care setting was a key indicator for the evaluation. The NGNs reported having professional development plans that were supported by their practices with many attending training and being released to attend the NETP programme to develop their clinical skills and competence. As a result of this training and the support at the practices most of the nurses reported an increase in their ability to undertake clinical processes and procedures, and identify patients' needs. The practice staff and NETP Coordinator also felt that the NGNs skills and experience had increased due to their time at the VLCA practice.

The support provided by the practice staff and the nurse preceptor was highly valued by the NGNs. Most of the NGNs were provided with opportunities to learn from other practice staff and other nurses in particular. A few nurses however, felt that the level of support was variable and that staff support was not as frequent as they would have liked. While many also valued the NETP programme, they felt that the programme would benefit from a greater focus on primary care.

The survey respondents felt that the NGN role has achieved impacts at a practice and patient level, and on the relationships between the practices, PHO and the DHB. The practice staff suggested that the NGN role has increased support available for existing staff, increased the availability of staff for succession planning and increased performance on targets. The NGN role had also enabled the practice to provide more appointments and subsequently see more patients.

The practice staff felt that the NGN role had improved patients' experience and allowed them to spend more time on addressing patients social care needs. These are important indicators of quality and sustainability of the VLCA practices. The evaluation criteria also did not anticipate the extent of agreement on the number of impacts reported by the stakeholders. It will be interesting to explore these further through the site visits planned for the next phase of the evaluation. Regardless, it is clear that the practice staff have identified a number of key impacts and benefits of the initiative for their practice.

The stakeholders also identified a number of benefits to having the NGN. Employing more local NGNs into primary care and reducing the burden on existing staff were frequently cited. Reducing the burden on staff also had wider benefits, as it enabled other practice staff to be released for their own professional development. The ability to grow the Māori and Pacific nursing workforce was also

frequently cited. This is an important finding as the match between the ethnicity of the NGNs and the enrolled population was important for the initiative. The survey suggests that the initiative is supporting practices to achieve this.

Another interesting benefit that was not anticipated in the evaluation criteria was the impact of providing support to the NGN. Practice staff identified the value that they got from providing support to the NGN as one of the key benefits of the initiative for them at an individual level. This provided staff with the opportunity to develop leadership and mentoring skills. The development of leadership within the practices was also valued by the business owners.

Business owners also valued the support that nurses provided to the existing workload and supporting patient care. Having more resources to support succession planning and increasing performance on targets were also key benefits for the business owners. The financial support for the initiative was also identified as a key benefit.

Contributing to the development of the future workforce and the promotion of the NETP programme in primary care were key benefits for the DHBs and PHOs. The opportunity to engage with different providers and increase connections with local practices was also valued by DHB and PHO staff.

Key benefits for the NGNs were the level of support provided to them and the opportunity to gain experience in the workplace. All of the nurses who responded to the survey would like to continue to work in primary care and all but one wanted to remain at their current practice. This is an important finding, as the initiative sought to increase graduate nurses in primary care and to sustain their interest in working in primary care, even if this was not in a VLCA practice. The survey findings suggest that this outcome has been achieved for those nurses who completed the survey. The next phase of the evaluation will aim to follow-up with the NGNs and see if they do remain at their current practice and/or in primary care.

Many of the stakeholders did not identify any key challenges to implementing the initiative. For some of the practices however, the time that needed to be spent on training the NGN was challenging. The reasons for this challenge can be explored in the next phase of the evaluation, as it could reflect specific contexts of the practices. The emphasis on secondary care in the NETP programme was also noted as a challenge. For some practices managing staff expectations was also a challenge. For some practices, some of the practice staff were less familiar on the role and scope of an NGN and care needed to be taken to ensure they were not overburdened.

The value of the initiative is reflected in the practices' willingness to have an NGN in the future. The challenge for some is how to fund this position. Some reported looking to other contracts to fund the role, increasing the nursing input into their model of care or seeking to increase their enrolled population, although the survey suggests an increase in the enrolled population has only been realised by some of the practices at the time of the survey. It will be important to follow-up with the practices and understand how they have been able to increase the number of enrolments at their practice. This insight could be shared with other practices to support the sustainability of the NGN and ultimately the sustainability of the practice.

Some business owners suggested that ongoing partial government funding could be used to continue to fund the NGN role while the practice continues to develop a more sustainable means of funding the role. There was a sense that twelve months was not long enough for some of the practices to be able to secure the level of funding needed to sustain the role.

Overall, the findings provided support for the successful implementation and initial impacts of the one-off funding for the NGN component of the VLCA Sustainability Initiative. It will be important to further validate and explore these impacts in the next phase of the evaluation.

## **8. NEXT STEPS**

This report has provided an overview of the key findings to date. The evaluation findings need to be reviewed and explored with key stakeholders to refine our interpretation of the key findings to date.

This analysis along with the MS Excel files on the practice profiling will be used to identify key practices to be invited to participate in the next phase of the evaluation. While we anticipate that practice characteristics will inform this section, the survey also suggests that the following may also warrant consideration:

- Levels of support for the NGN, perhaps exploring a practice where this has been more challenging or a new experience i.e. the first time that they have had an NGN.
- Practice level impacts, such as the ability to increase enrolments.
- DHB, PHO and practice connections, such as understanding the contexts or approach that has supported greater connections.

The findings from this phase also suggest that the following may warrant further exploration:

- The specific ways in which the NETP programme could be better tailored to further support the training of NGNs in primary care.
- The level and types of cultural support that are being provided to NGNs.
- To further explore the broader practice level benefits, such as increased leadership and professional development at the practices.
- To substantiate the impacts identified by the stakeholders through the analysis of practice level data.
- To further understand the challenges and opportunities for practices to sustain the NGN at their practice.
- To explore the development of nurse-led models in relation to the NGN.